02928

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

937

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County Carroll

City or town Near Manchester Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Near Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary E. Alban.

3. (b) Social Security Number ✓

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband ~~or wife~~ Henry W. Alban

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years About 89 Months — Days — If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name William Hare
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Frank
15. Birthplace Maryland

16. Informant Mrs Albert Reed
Address Hampstead, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof March 23/40
(month) (day) (year)

Cemetery or crematory Grave Run

Location Grave Run, Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. Mar. 21 1940 Mrs. W. G. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 21 st 1940, at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 th 1939, to Mch 21 st 1940, and that I last saw her alive on Dec 12 th 1940.

Immediate cause of death Chronic hypocondritis

DURATION 3 mills

Due to Infirmities of age

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D M Resh
M. D. or other

Address Hampstead Md Date signed 3/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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APR 5 1940
BUREAU V. S.

02929

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH (83 ra)

County Carroll Registration Dist. No. 80

Village or City New Windsor, Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mrs. Laura L. Baile If U. S. Veteran, specify WAR

(a) Residence: No. New Windsor, Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of late Joseph D. Baile

6. DATE OF BIRTH (month, day, and year) February 15, 1850

7. AGE Years 90 Months 0 Days 18 If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housework.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

FATHER

13. NAME Henry M. Flickinger

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Julia Crawmer

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT (Address) Mr. Guy E. Baile New Windsor, Md

18. BURIAL, CREMATION, OR REMOVAL Place Greenwood Cemty Date March 5, 1940

19. UNDERTAKER (Address) C. M. Waltz Winfield, Md.

20. FILED March 4, 1940 Ernest S. Bundet Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 3 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from February 29, 1940, to March 3, 1940

I last saw her alive on March 2, 1940; death is said to have occurred on the date stated above, at 11:00 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	2-29-40
Arterio-Sclerosis	—

Other Contributory Causes of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) J. Sterling Geatty M. D.

(Address) New Windsor, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home.** For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02930

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 11 mos., 7 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1833 Orleans Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Jane Lulu Ballard

3. (b) Social Security Number

4. Sex: Female

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife William Ballard

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 19, 1884

8. AGE: Years 55 | Months 8 | Days 10 | If less than one day ____ hrs. ____ min.

9. Birthplace Loneytown, Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Sippy Miller
13. Birthplace Loneytown, Maryland

MOTHER
14. Maiden name Sarah Gunn
15. Birthplace Loneytown, Maryland

16. Informant Dr. Reuben Hoffman

Address Henryton, Maryland

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof 4/2/40
(month) (day) (year)

Cemetery or crematory Mt Galeway

Location Balto.

18. Funeral director Elroy O Wilson

Address 1000 Brantley ave.

19. 3/29/40 19 Albert R. Swankhouse
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1940 19 10:30 A.M. at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22, 1940 to March 29, 1940, and that I last saw her alive on March 29, 1940 19

Immediate cause of death Pulmonary Tuberculosis

Due to --

Due to --

Other conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Major findings:

Of operations --

Of autopsy No autopsy

DURATION Feb. 1939

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other

Address Henryton, Maryland Date signed 3/29/40

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (120-a)

02931

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Sykesville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME John Wm Barber Jr.

3. (b) Social Security Number None

4. Sex M.

5. Color or race W.

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 20 - 1932

8. AGE: Years 7 8 | Months 2 | Days 15 | If less than one day ____ hrs. ____ min.

9. Birthplace Mt. Westminster Carroll Md.

(Town, county, and state)

10. Usual occupation School boy.

11. Industry or business —

FATHER 12. Name John Wm Barber

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Dorothy H. Brown

MOTHER 15. Birthplace New York City

16. Informant Mrs. Dorothy H. Barber.

Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 8th. 1940 (month) (day) (year)

Cemetery or crematory Pleasant Grove

Location Carroll Co. Md.

18. Funeral director C. H. Weer

Address Sykesville, Md.

19. Mar. 6 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1940, at 6a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —; and that I last saw h — alive on — 19 —.

Immediate cause of death Acute Gastro-enteritis — DURATION 10 a.

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE J. Howard Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 3-6-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

02932

Reg. Dist. No. 26

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 173 W. Main Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 35 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Dorsey Bell Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of ~~husband~~ or wife Effie E. Hess

6(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) May 12, 1862

8. AGE:

Years	Months	Days	If less than one day
77	9	28	hrs. min.

9. Birthplace Baltimore Co. Maryland
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

FATHER
12. Name John Dorsey Bell Jr.
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Ellen (Bell)
15. Birthplace Maryland

16. Informant Mrs. Effie E. Bell
Address 173 W. Main St. Westminster Md

17. Burial Date thereof Mar. 12 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Lutheran Cemetery
Location Taneytown Md.

18. Funeral director H B Bankard & Son
Address Westminster, Md.

19. 3/11 1940 H Elwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10th 1940, at 6 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/3/38 19 , to 3/10 19 40 , and that I last saw h alive on March 19 40 .

	DURATION
Immediate cause of death Hypostatic Pneumonia	1 week
Due to Chronic Myocarditis	5 yrs.
Due to	
Other conditions arteriosclerosis Chronic Nephritis	10 yrs 5 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. H. Billingslea M. D. or other
Address Westminster, Md. Date signed 3/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93rd)

02933

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 30 yrs.
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 337 E. North Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Minnie Bender
3. (b) Social Security Number:

4. Sex: Female
5. Color or race: white
6. (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: unknown
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan 14, 1871
8. AGE: Years 69 Months 1 Days 27 If less than one day: hrs. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation:
11. Industry or business: National Biscuit Co
FATHER 12. Name: Henry Hooper
13. Birthplace: Baltimore
MOTHER 14. Maiden name: Susan Hinds
15. Birthplace: Baltimore Md.
16. Informant: Dr. Jas L. Hooper
Address: 337 E North Ave Baltio
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-13-40 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Baltimore
18. Funeral director: Frederick A. Dole
Address: 1200 W. Lombard St.
19. 3-10-40 (Date rec'd by registrar) 19 Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1940, at 9-5 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1938, to Mar 10 1940, and that I last saw her alive on March 10 1940.

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to	
Due to Arterio Sclerosis & Hypertension	14 yrs
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M. A. Martin M. D. or other
Address: Sykesville Date signed: Mar 10-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02934

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 25 days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: --
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Benthall

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

8 (b) Name of husband or wife: Beddick Benthall
6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): April 13, 1908

8. AGE: Years	Months	Days	If less than one day
31	11	2	---- hrs. ---- min.

9. Birthplace: Habgood, N. C. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: --

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Jennie Mabry
15. Birthplace: Habgood, N. C.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-16-40 (month) (day) (year)
Cemetery or crematory: St Lukes Cemetery
Location: Sykesville
18. Funeral director: C. Harry Eves
Address: Sykesville Md.

19. 3/15/40 (Date rec'd by registrar) 19 Albert R. Swansbrough Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15, 1940 19---, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19, 1940 19---, to March 15, 1940
and that I last saw her alive on March 15, 1940 19---

Immediate cause of death: Pulmonary Tuberculosis — DURATION: May 1939
Due to: --
Due to: --
Other conditions: ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)
Address: Henryton, Maryland Date signed: 3/15/40

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APR 3 1940
BUREAU V. S.

02935

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County: Carroll Co

City or town: Union Bridge Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State _____ County _____

City or town _____ Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)

Street No. _____
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Charles Le Gean Black

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ or wife: Dead

6(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.): ✓

8. AGE: Years: 60 | Months | Days | If less than one day _____ hrs. _____ min.

9. Birthplace: Uniontown, Md
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business

FATHER
12. Name: Charles Black
13. Birthplace: Carroll Co

MOTHER
14. Maiden name: Emma Gibson
15. Birthplace: Carroll Co

16. Informant: Emma Gibson

Address: Union Bridge, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-26-40 (month) (day) (year)

Cemetery or crematory: Fairview

Location: Taylorsville, Md

18. Funeral director: Raymond K. Wright

Address: Union Bridge, Md.

19. March 25 1940 (Date rec'd by registrar) P. Eckman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-24- 1940, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/24 1940, to 3/24 1940, and that I last saw him alive on 3/24 1940.

Immediate cause of death: Cerebral Hemorrhage — DURATION: 6 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work?

23. SIGNATURE: T. H. Legg MD
M. D. or other

Address: Union Bridge Date signed 3/25/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02936

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium
Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 19 days

Stay in this community (yrs., or mos., or days) (Above.)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 814 Vincent St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR --

3. (a) FULL NAME Ernest Thomas Blake

3. (b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife ---

6(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1919

8. AGE:

Years	Months	Days	If less than one day
21	0	14	---hrs. ---min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Scholar

11. Industry or business --

FATHER
12. Name Thomas Blake
13. Birthplace Westriver, Md.

MOTHER
14. Maiden name Mary Brown
15. Birthplace Catonsville, Md.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 15 40 (month) (day) (year)

Cemetery or crematory Mt Auburn

Location Baltimore City

18. Funeral director Thomas E. Kelbaugh

Address 1303 Brentwan St.

19. 3/12/40 (Date rec'd by registrar) 19 Albert R. Swanbourne Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1940 19 --, at 1:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23, 1940 19 --, to March 12, 1940 19 --, and that I last saw him alive on March 12, 1940 19 --.

Immediate cause of death Pulmonary Tuberculosis — DURATION Aug. 1939

Due to ---

Due to ---

Other conditions ---

(Include pregnancy within 3 months of death)

Major findings:

Of operations --

Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of --

Where did injury occur? --- (City or town) --- (County) --- (State)

Injured at home, farm, industry, public place (where?) --

Means of injury --- Injured at work? --

23. SIGNATURE Reuben Hoffman M. D.
M. D. or other

Address Henryton, Maryland Date signed 3/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 15 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

02937

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County Carroll
City or town Millers, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 3 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Millers, Md.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No.

3. (a) FULL NAME Mrs. Amanda E. Bowers

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Charles E. Bowers
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 1, 1874

8. AGE: Years	Months	Days	If less than one day
65	10	13	____ hrs. ____ min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name William Poole
13. Birthplace Maryland

MOTHER
14. Maiden name Eliza V. Hall
15. Birthplace Maryland

18. Informant Mrs Allen Rohrbaugh
Address Millers, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 17, 1940 (month) (day) (year)
Cemetery or crematory Taylorsville Methodist
Location Taylorsville Md.

18. Funeral director C. M. Walt
Address Westfield Md.

19. Mar. 15 1940 (Date rec'd by registrar) Mrs. W. F. S. Danner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1940, at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10th 1940, to March 18th 1940 and that I last saw h- or- alive on March 18th 1940

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy no autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D M Resh M. D. or other
Address Hampstead Md Date signed 3/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

02938

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Finksburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Finksburg

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 7 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Finksburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Mary Catherine Bowers

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1939

8. AGE: Years | Months 7 | Days 4 | If less than one day hrs. min.

9. Birthplace Carroll Co.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name James Bowers
13. Birthplace Carroll Co.

MOTHER
14. Maiden name Catherine Mann
15. Birthplace Carroll Co.

16. Informant James Bowers
Address Finksburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 7, 1940 (month) (day) (year)

Cemetery or crematory Finksburg

Location Carroll Co.

18. Funeral director J. F. Eline & Sons
Address Reisterstown, Md.

19. 3/6 1940 L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6th 1940, at 5 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1940, to March 9 1940, and that I last saw her alive on March 6 1940

Immediate cause of death

Primary Bronchopneumonia

Due to There was no associated disease. C.W.G.R.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 3 day

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Paul Hill M.D.
M.D. or other

Address Reisterstown Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

02939

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Westminster (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 18½ Union St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): about 40 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No.: 18½ Union St. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: X

3. (a) FULL NAME: John Nathan Briscoe

3. (b) Social Security Number: X none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	widowed.

B (b) Name of husband or wife: Birdie Costley Briscoe
6(c) If alive, give age: X years

7. Birth date of deceased (mo., day, yr.): 1874 - month not known

8. AGE: Years	Months	Days	If less than one day
66	X	X	hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: X

FATHER
12. Name: Nathan Briscoe
13. Birthplace: Md.

MOTHER
14. Maiden name: Sally Briscoe
15. Birthplace: Md.

16. Informant: Joshua Magruder
Address: 18½ Union St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 25 40 (month) (day) (year)
Cemetery or crematory: Western Chapel
Location: near Westminster, Md.

18. Funeral director: J. E. Myers, Jr.
Address: Westminster, Md.

19. 3/23 19 40 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1940, at ( ) M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-12- 1939, to March 22 1940, and that I last saw him alive on March 21, 1940

Immediate cause of death	DURATION
Carcinomatosis	1938
Due to Carcinoma of Stomach	?
Due to	
Other conditions Chronic Myocarditis	?

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Clifford M. Taylor M.D. M. D. or other
Address: Westminster Date signed 3/23/40

RECEIVED
APR 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83a)

02940

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 3 mo. 16 da.
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3416 Lewyn Falls Pkwy
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Evelyn Bull

3. (b) Social Security Number

4. Sex F
5. Color or race W.
6. (a) Single, married, widowed, or divorced divorced.
6 (b) Name of husband or wife Unknown
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) (mo.-day unka) 1893
8. AGE: Years 47 Months Days If less than one day hrs. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name John Summerfield Bull
13. Birthplace Baltimore Md
MOTHER 14. Maiden name Jennie Littig Cole
15. Birthplace Sykesville Md.
16. Informant Hospital Records
Address Sykesville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-20-40 (month) (day) (year)
Cemetery or crematory Greenmount Cemetery
Location Balto Md.
18. Funeral director C. Harry Weer
Address Sykesville Md.
19. 3-17-40 19 C Harry Weer (Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1940, at 2 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29 1939, to Mar. 16 1940
and that I last saw her alive on Mar 16 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	5-11-40
Due to Cerebral Arteriosclerosis	1936
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M Rees M. D. M. D. or other
Address Sykesville Md Date signed 3-16-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02941

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County ~~Carroll~~ Baltimore
City or town Relay Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Leanna Jackson Burall

3. (b) Social Security Number

4. Sex F.
5. Color or race W.
6. (a) Single, married, widowed, or divorced widowed
6 (b) Name of husband or wife William T. Burall
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) June 2, 1863

8. AGE: Years 76 | Months 9 | Days 14 | If less than one day ____ hrs. ____ min.

9. Birthplace Carroll County Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Wesley Harrison
13. Birthplace Carroll County Md
MOTHER 14. Maiden name Eliza Baker
15. Birthplace Carroll County Md
16. Informant Hospital Records
Address Sykesville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 19, 1940 (month) (day) (year)
Cemetery or crematory Prospect
Location Mt. Airy Md.
18. Funeral director C. H. Weer
Address Sykesville Md.
19. Mar 17 1940 (Data rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16th 1940, at 7.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 28 1940, to Mar. 16 1940, and that I last saw her alive on Mar. 16 1940.

Immediate cause of death: Influenza — DURATION: 2-28-40
Due to
Due to General Arteriosclerosis Chronic Valvular Heart Disease — 1936
Other conditions
(Include pregnancy within 8 months of death)
Major findings:
Of operations
Of autopsy No.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE Maud M. Rees M. D. M. D. or other
Address Sykesville Md. Date signed 3-16-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02942

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll Co.
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 20 Union St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 60 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 20 Union St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR X

3. (a) FULL NAME Charles Edward Charnes

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

8 (b) Name of husband or wife Inez Omega Charnes
6(c) If widow give age 30 years

7. Birth date of deceased (mo., day, yr.) not known

8. AGE: Years	Months	Days	If less than one day
about 62	X	X	hrs. min.

9. Birthplace Westminster Md. Carroll Co.
(Town, county, and state)
10. Usual occupation laborer
11. Industry or business X
FATHER 12. Name John Charnes
13. Birthplace Carroll Co. Md.
MOTHER 14. Maiden name Alice Bruce
15. Birthplace Westminster Md.
16. Informant Mrs. Charles Edward Charnes
Address 20 Union St. Westminster
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 / 1 / 40 (month) (day) (year)
Cemetery or crematory Ellsworths Cem.
Location Near Westminster, Md.
18. Funeral director J. E. Myers Jr.
Address Westminster, Md.
19. 3/31/1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1940, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1940 to March 30 1940, and that I last saw h[illegible] alive on March 28 1940.

	DURATION
Immediate cause of death Acute Cardiac Dilatation	30 min.
Due to Chr. Cardiovascular renal disease	?
Due to Hypertension C.V.D.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford M. Taylor M.D. M. D. or other
Address Westminster, Md. Date signed

RECEIVED
APR 4 1940
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

02943

CERTIFICATE OF DEATH

(97)

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 5 mo. 23 da.
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County ~~Carroll~~
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1331 Caroline Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mollie Clapp

3. (b) Social Security Number

4. Sex F.
5. Color or race W.
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Clapp
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 27, 1862
8. AGE: Years 77 Months 11 Days 3 If less than one day hrs. min.
9. Birthplace Washington D.C. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name William Sherwood
13. Birthplace Baltimore Md
MOTHER 14. Maiden name Sarah (Unknown)
15. Birthplace Baltimore Md.
16. Informant Hospital Records
Address Sykesville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-3-40 (month) (day) (year)
Cemetery or crematory Baltimore Cemetery
Location Baltimore Md.
18. Funeral director Wm Cook
Address 1217 St Paul St Balto Md.
19. 3-31-40 19 (Date rec'd by registrar) C. Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1940, 8:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 1939, to Mar. 30 1940, and that I last saw her alive on March 30 1940.

Immediate cause of death: Arteriosclerosis — DURATION: 1939
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D. M. D. or other
Address Sykesville Md. Date signed 3.31.40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 3 1946
BUREAU V. S.

02944

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:

County: Carroll

City or town: Rural m. Berrett
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 4 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural m Berrett Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.D. Sykesville Md
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: Mrs. Athia Sophia Condon

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

B (b) Name of husband or wife: late Edward E. Condon

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 28, 1863

8. AGE: Years 76 | Months 7 | Days 23 | If less than one day ____ hrs. ____ min.

9. Birthplace: Calvert Co. Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Unknown Fowler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Mrs. W.R. Etzler

Address: R.D. Sykesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 23, 1940 (month) (day) (year)

Cemetery or crematory: Prospect

Location: m. Mt. Airy, Fred. Co. Md

18. Funeral director: C.M. Waltz

Address: Winfield Md

19. March 22 1940 (Date rec'd by registrar) Eva M. Hewitt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21, 1940, at 5:A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-19-40 19__ to death 19__, and that I last saw her alive on 3/19/40 19__.

Immediate cause of death: chronic myocarditis chronic nephritis arteriosclerosis senile changes

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W. H. Lawson M.D. M. D. or other

Address: Sykesville, Md. Date signed 3/20/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 4 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

02945

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hosp.

Stay in hospital or inst. (yrs., or mos., or days): 2 yr. 10 days

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 1251 Carroll St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Elizabeth Cook

3. (b) Social Security Number: —

4. Sex: female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 12th - 1908

8. AGE: Years: 31 Months: 11 Days: 10 If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at home

FATHER 12. Name: Samuel Cook

13. Birthplace: Germany

MOTHER 14. Maiden name: Barbara Pfister

15. Birthplace: Germany

16. Informant: Samuel Cook

Address: 1251 Carroll St. Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-25-40 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Balto Md.

19. Funeral director: John J. Cowan & Son

Address: 901 Hollins St.

19. 3-22-40 (Date rec'd by registrar) 19 C. Harry Wier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1940, at 12-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 12 1938, to Mar 22 1940, and that I last saw her alive on Mar 22 1940.

Immediate cause of death: Injured by fall Sub-drachmoid Hemorrhage

Due to

Due to

Other conditions: Epilepsy (Include pregnancy within 3 months of death)

Major findings: ~~Of operations~~ Blood in Spinal fluid

Of autopsy: Refused

DURATION: Mar 17-40; 21 yrs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~: Accident Date of Mar 17/40

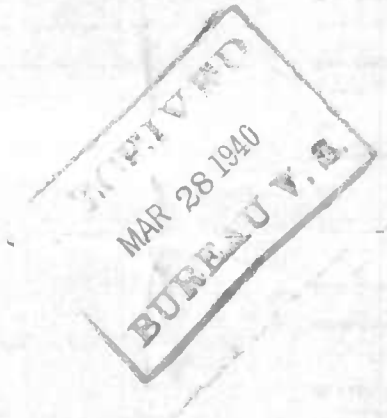
Where did injury occur? Sykesville (City or town) (County) Md (State)

Injured at home, farm, industry, public place (where?): State Road

Means of injury: Fall from car Injured at work? —

23. SIGNATURE: H. H. Mastin M. D. or other

Address: Sykesville Date signed: Mar 22/40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MAR 28 1940
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02946

CERTIFICATE OF DEATH

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Rural - Mt Airy

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED.

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural - Mt Airy Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Ruby Irene Cook

3. (b) Social Security Number

4. Sex F | 5. Color or race Wh | 6.(a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife Not married.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14 - 1940

8. AGE: Years | Months 2 | Days 5 | If less than one day hrs. min.

9. Birthplace Mt Airy Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name George E. Cook Jr

13. Birthplace Gettysburg Pa

MOTHER 14. Maiden name Helen I. Johnson

15. Birthplace Md

16. Informant Geo E. Cook

Address Mt Airy

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 20, 1940 (month) (day) (year)

Cemetery or crematory Mt. Zion

Location Rt. 2 Mt. Airy, Carroll Co. Md

18. Funeral director C. M. Waltz

Address Westminster, Md

19. Mar 20 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19 1940, at 5 a 25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Bronchio-Pneumonia — DURATION

Due to Not Known

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. J. Monck Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 3/19/40

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APR 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02947

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A16

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 28 days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Brentwood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 101 Johns St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Alvin Jackson Davis

3. (b) Social Security Number: 218-05-6193

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Nov. 6, 1916

8. AGE: Years: 23 | Months: 4 | Days: 9 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Anderson, S. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: Oscar Davis
13. Birthplace: Williamstown, S. C.

MOTHER
14. Maiden name: Helen Wilson
15. Birthplace: Abbeville, S. C.

16. Informant: Dr. Reubeh Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar, 18 194 (month) (day) (year)
Cemetery or crematory: Mt Harmony
Location: Washington D.C.

18. Funeral director: J. B. Johnson
Address: Hyattsville, Md

19. 3/15/40 (Date rec'd by registrar) Deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15, 1940 2:45 A.M 19 ____, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 16, 1940 19 to March 15, 1940 19, and that I last saw him alive on March 15, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 1939

Due to: --

Due to: --

Other conditions: ---

(Include pregnancy within 3 months of death)

Major findings:

Dt operations: --

Dt autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 3/15/40

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APR 8 1940
BUREAU V. S.

02948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (S)

CERTIFICATE OF DEATH

Reg. Dist. No. 84

1. PLACE OF DEATH:

County Carroll

City or town New Windsor
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town New Windsor Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Foetus Dorsey

3. (b) Social Security Number

4. Sex F

5. Color or race C

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Still born

8. AGE: Years — Months — Days — If less than one day ___ hrs. ___ min.

9. Birthplace New Windsor Carroll Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Rainey F. Dorsey
13. Birthplace Libertytown Md

MOTHER
14. Maiden name Catherine E. Squirrell
15. Birthplace

16. Informant Catherine E. Dorsey
Address New Windsor Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Ons Presence

Location

18. Funeral director Rany F Dorsey
Address New Windsor

19. March 6 1940
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 6 1940, 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —,
and that I last saw h alive on — 19 —.

Immediate cause of death Still birth

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

DURATION —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE J. T. Marsh M. D.
M. D. or other

Address New Windsor Md Date signed 4/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

02949

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Hanryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 1 Mo. 23 days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Glencoe Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Dorothy Helease Dorsey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

B (b) Name of husband or wife: --

B(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): Sept. 4, 1923

8. AGE:

Years	Months	Days	If less than one day
16	5	1	____ hrs. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: --

FATHER

12. Name: Travless Glascoe

13. Birthplace: Sparks, Md.

MOTHER

14. Maiden name: Dora Dorsey

15. Birthplace: Sparks, Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 6, 1940 (month) (day) (year)

Cemetery or crematory: Stevenson Chapel

Location: Sparks

18. Funeral director: Landon M. Brooks

Address: Sparks, Md

19. 3/5/40 (Date rec'd by registrar) 19__ Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1940 19__, at 2.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 11, 1940 19__, to March 5, 1940 19__, and that I last saw him or alive on March 5, 1940 19__.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: No Autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 3/5/40

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02950

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 2 Mos. 14 Days
Stay in this community (yrs., or mos., or days): (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Fruitland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Fruitland
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Mary Ellen Stanford Dredden

3. (b) Social Security Number: 222-03-7728

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Agnitatious Dredden
6(c) If alive, give age: Unknown years
7. Birth date of deceased (mo., day, yr.): Jan. 17, 1917
8. AGE: Years: 23 Months: 2 Days: 1 If less than one day: ____ hrs. ____ min.
9. Birthplace: Fruitland, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: ---

FATHER
12. Name: Raymond Stanford
13. Birthplace: Fruitland, Md.

MOTHER
14. Maiden name: Sadie Schokley
15. Birthplace: Fruitland, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 24-1940 (month) (day) (year)
Cemetery or crematory: Family
Location: Fruitland Md
18. Funeral director: James H. Stewart
Address: Salisbury Md

19. 3/18/40 (Date rec'd by registrar) Albert R. Swanckhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18, 1940 19____, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4, 1940 19____, to March 18, 1940 19____, and that I last saw h er alive on March 18, 1940 19____.

Immediate cause of death: Pulmonary Tuberculosis J — DURATION: June 1939
Due to: ---
Due to: ---
Other conditions: ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 3/18/40

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

CERTIFICATE OF DEATH

02951

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Carroll

City or town Taneytown Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Taneytown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Joanna M. Eyler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife Grayson Eyler

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24 1866

8. AGE:

Years	Months	Days	If less than one day
73	9	27	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER 12. Name Arthur Bitzeberger

13. Birthplace Md

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs Clarence Shank

Address Taneytown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 26 1940 (month) (day) (year)

Cemetery or crematory Int Hope Woodsboro

Location Woodsboro Md

18. Funeral director C O Fuss & Son

Address Taneytown Md

19. March 26 1940 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1939, to Mar. 24 1940, and that I last saw h[illegible] alive on March 24 1940.

Immediate cause of death	DURATION
Chronic Nephritis	
Due to Arteriosclerosis	
Due to	
Other conditions Atrophic Arthritis, Anemia (Secondary), Chronic Myocarditis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D. M. D. or other

Address Taneytown, Md. Date signed 3/25/40

RECEIVED
APR 2 1940
BUREAU V. S.

02952

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium
Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 11 Mos. 21 days.
Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 702 W. Saratoga St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR --

3. (a) FULL NAME
Laney Fields

3. (b) Social Security Number
--

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married

B (b) Name of husband or wife Unknown
6(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) May ?, 1899

8. AGE: Years 40 | Months 10 | Days ? | If less than one day ___ hrs. ___ min.

9. Birthplace Florida
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Unknown

FATHER
12. Name Arrin Fields
13. Birthplace Florida

MOTHER
14. Maiden name Lizza Wade
15. Birthplace Florida

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Cremation (Burial, cremation, or removal? Which?) Date thereof 3/18/1940 (month) (day) (year)
Cemetery or crematory City Mo Lodge
Location Balto Md

18. Funeral director Mrs S. T. Hemsley
Address 578 W. Biddle St

19. 3/15/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1940 19 , at 4:10 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1939 19 , to March 15, 1940 and that I last saw him alive on March 15, 1940 19

Immediate cause of death Pulmonary Tuberculosis — DURATION April 1938

Due to --

Due to ---

Other conditions ---
(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide -- Date of -
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Md. Date signed 3/15/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 9 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02953

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS AT5

1. PLACE OF DEATH:
County Carroll
City or town Near Manchester
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Near Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR —

3. (a) FULL NAME Mary Alice Firey

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Nathaniel Firey (deceased) 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12 - 1846

8. AGE:

Years	Months	Days	If less than one day
93	3	8	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation House Wark
11. Industry or business
FATHER 12. Name Mr. Spielman
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Bombager
15. Birthplace Maryland
16. Informant Mrs. W M Frank
Address Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-23-40 (month) (day) (year)
Cemetery or crematory Cemetery
Location Bagerstadtown Md
18. Funeral director Jakob Winkleman Sons
Address Manchester Md
19. Mar. 22 1940 (Date rec'd by registrar) Mrs. M. P. L. Demmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20th 1940, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22nd 1940, to March 20th 1940 and that I last saw h alive on Feb 22nd 1940.

	DURATION
Immediate cause of death Angina Pectoris	
Due to Infirmities of age	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy No autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D M Resh M. D. or other
Address Hampstead Md Date signed 3/21/40

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

02954

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
County: Carroll
City or town: Taneytown R.D.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Taneytown, R.D. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Charles H. Foreman
3. (b) Social Security Number: none

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Jan 8, 1940

8. AGE: Years: 0 Months: 2 Days: 7 If less than one day ____ hrs. ____ min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business: none
FATHER
12. Name: William C. Foreman
13. Birthplace: Md
MOTHER
14. Maiden name: Zola V. Hess
15. Birthplace: Md
16. Informant: William C. Foreman
Address: Taneytown Md Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 17, 1940 (month) (day) (year)
Cemetery or crematory: United Brethren
Location: Taneytown
18. Funeral director: Ott Fuss & Son
Address: Taneytown Md.
19. Mar. 17, 1940 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mch 15 1940, at 3 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mch 14 1940, to ____ 19__, and that I last saw him alive on Mch 14 1940.
Immediate cause of death: Acute Tuberculosis
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: R. F. Wells MD M. D. or other
Address: Taneytown Md Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02955

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Lynwood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Alfred Foster

3. (b) Social Security Number: 579-09-1836

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	colored	widower

6 (b) Name of husband or wife: unknown
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3/7/12

8. AGE: Years	Months	Days	If less than one day
28		20	hrs. min.

9. Birthplace: Lakeland, Maryland (Town, county, and state)
10. Usual occupation: Pin Boy
11. Industry or business: ---

FATHER
12. Name: George Foster
13. Birthplace: A. A. Co., Md.

MOTHER
14. Maiden name: Susie Johnson
15. Birthplace: Virginia

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3. 29. 40 (month) (day) (year)
Cemetery or crematory: St Lukes Cemetery
Location: Sykesville Md.

18. Funeral director: C. Harry Weer
Address: Sykesville Md.

19. 3/27/40 (Date rec'd by registrar) 19 Albert R. Swankhouse Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/27/40 2:30 A.M., 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/20/40 19 to 3/27/40 19, and that I last saw him alive on March 27, 1940 19

Immediate cause of death	DURATION
Pulmonary tuberculosis	1935

Due to	
Due to ----	
Other conditions ----	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ----
Of autopsy: no autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): 0-
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M. D.
M. D. or other
Address: Henryton, Maryland Date signed: 3/27/40

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

02956

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or insf. (yrs., or mos., or days) 2 Mos. 5 days
Stay in this community (yrs., or mos., or days) (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town Nanjemoy, Grayton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James Edward Franklin, Jr.

3. (b) Social Security Number --

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife --
6(c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) June 21, 1905
8. AGE: Years 34 | Months 8 | Days 23 | If less than one day ___ hrs. ___ min.
9. Birthplace Nanjemoy, Md. (Town, county, and state)
10. Usual occupation Barber
11. Industry or business --
FATHER 12. Name James Franklin
13. Birthplace Nanjemoy, Md.
MOTHER 14. Maiden name Elizabeth Carter
15. Birthplace Nanjemoy, Md.
16. Informant Dr. Reuben Hoffman
Address Henryton, Md.
17. (Burial, cremation, or removal. Which?) Date thereof March 18, 1940 (month) (day) (year)
Cemetery or crematory Grayton Md
Location
18. Funeral director Theodore Matthews
Address 614 4th St. Wash. D.C.
19. 3/15/40 (Date rec'd by registrar) 19 Albert R. Swanehaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1940 3:40 A.M. 19 , at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10, 1940 19 , to March 15, 19 40 , and that I last saw him alive on March 15, 1940 19
Immediate cause of death Pulmonary Tuberculosis
DURATION July 1937
Due to --
Due to ---
Other conditions ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations ---
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury -- Injured at work? ---

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 3/15/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02957

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days): 8 yrs. 5 mos.
Stay in this community (yrs., or mos., or days): Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland, County: Allegany.
City or town: Cumberland. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 46 Lamont.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No record.

3. (a) FULL NAME: Arthur Frantz.

3. (b) Social Security Number: #.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male.	White	Divorced.

6 (b) Name of husband or wife: Susie Gray.
6(c) If alive, give age: Unk. years

7. Birth date of deceased (mo., day, yr.): Unknown.

8. AGE: Years	Months	Days	If less than one day
57.	Unk.	Unk.	hrs. min.

9. Birthplace: Maysville, Md.
(Town, county, and state)

10. Usual occupation: Blacksmith and Saloon Keeper.

11. Industry or business:

FATHER
12. Name: Henry Frantz
13. Birthplace: West Virginia.

MOTHER
14. Maiden name: Maggie Hawk.
15. Birthplace: West Virginia.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 5-40 (month) (day) (year)
Cemetery or crematory: Cumberland Md
Location: Cumberland, Md.

18. Funeral director: V. L. Zemperene.
Address: Cumberland, Md.

19. Mar 4 1940 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3, 1940., at 6.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3, 1931, to March 3 1940, and that I last saw him alive on March 3, 1940.

Immediate cause of death	DURATION
Coronary Thrombosis	3-3-40.
Due to	
Due to	
Other conditions: General Arteriosclerosis prior to	10-3-31.

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D.
M. D. or other
Address: Sykesville, Md. Date signed: 3-3-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1228)

02958

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 mos. 17 days

Stay in this community (yrs., or mos., or days) 10 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3316 E. Baltimore Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Franz

3. (b) Social Security Number Conn. 147-09-3223

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 17, ~~1914~~ 1917

8. AGE: Years	Months	Days	If less than one day
22 ~~25~~	3	9	hrs. min.

9. Birthplace Italy (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Carmello Franz

13. Birthplace Sicily, Italy.

MOTHER 14. Maiden name Anna Pasalaqua

15. Birthplace Sicily, Italy

16. Informant Hospital Records

Address Sykesville, Md.

17. Holy Redeemer Cem. (Burial, cremation, or removal. Which?) Date thereof March 29-1940 (month) (day) (year)

Cemetery or ~~crematory~~ Holy Redeemer Cemetery

Location Baltimore Md

18. Funeral director Frank Della Mora

Address 52 N. Morley St. Baltimore Md

19. 3-27-40 (Date rec'd by registrar) 19 C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1940, at 4. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9 1940, to March 26 1940, and that I last saw him alive on March 26 1940

Immediate cause of death	DURATION
Intestinal Obstruction	12 hours
Due to	
Due to	
Other conditions Epilepsy	10 years.

(Include pregnancy within 3 months of death)

Major findings:

Of operations Duodenal Obstruction due to adhesions

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D. (M. D. or other)

Address Sykesville, Md. Date signed 3-26-40

Change of age: Letter 4/1/40 under Dr. Jones

RECEIVED
APR 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02959

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: Springfield State Hospital
Stay in hospital or Inst. (yrs., or mos., or days): 5 days
Stay in this community (yrs., or mos., or days): 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balt
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 2210 Orleans St.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Robert Hearman Glodden

3. (b) Social Security Number: Trans. 225-05-0003

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife: Unk
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 29 1890

8. AGE: Years	Months	Days	If less than one day
49	6	9	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Charles W. Glodden
13. Birthplace: Maryland
MOTHER 14. Maiden name: Charlotte Elizabeth Jones
15. Birthplace: Maryland
16. Informant: Hospital Records
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-12-40 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Balto Md
18. Funeral director: John Villiers
Address: Orleans Washington Sts Balto
19. 3-10-40 (Date rec'd by registrar) 19 Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 10 1940, at 4:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 4 1940, to Mar 10 1940
and that I last saw h[illegible] alive on Mar 10 1940.

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to	
Due to: Alcoholic Cirrhosis Liver	years
Delirium Tremens	1 wk.
Other conditions: Chronic Endocarditis	years

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Chronic Endocarditis
Alcoholic Cirrhosis Liver
Of autopsy: Bronchopneumonia

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Max Hayman M. D. or other
Address: Springfield State Hospital Date signed 3/10/40

RECEIVED
MAR 15 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02960

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 27 yrs. 7 mos. 20 da.
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore (If outside city or town limits, write RURAL NEAR and give town) Ward No.
Street No. 339 So Chester St. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Annie Glynn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single.

6 (b) Name of husband or wife

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years Probable 70 | Months | Days | If less than one day hrs. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Ireland

MOTHER 14. Maiden name Unknown
15. Birthplace Ireland

16. Informant Hospital Records
Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 14 40 (month) (day) (year)

Cemetery or crematory Mount Cathedral
Location Frederick Rd.

18. Funeral director Fully & Zeiler Inc
Address 413 S Mulberry St

19. 3-15-40 (Date rec'd by registrar) Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1940, at 5.35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1940, to Mar. 14 1940, and that I last saw her alive on March 13 1940.

Immediate cause of death	DURATION
Lobar Pneumonia	3-9-40
Due to	to
Due to Advanced Condition	3-14-40
	1912
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Dt operations
Dt autopsy Yes

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M. Rea M.D. M. D. or other
Address Sykesville Md Date signed 3-14-40

RECEIVED
MAR 23 1940
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

02961

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll Co.
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 117 E. Green St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 34yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 117 E. Green St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR X

3. (a) FULL NAME Emily Effie Goodwin

3. (b) Social Security Number X

4. Sex: female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband ~~or wife~~: H. Price Goodwin
6(c) If alive, give age: 79 years
7. Birth date of deceased (mo., day, yr.): Oct. 12, 1869
8. AGE: Years 70 | Months 4 | Days 28 | If less than one day: hrs. min.
9. Birthplace: Mechanicsville Carroll Co. Md. (Town, county, and state)
10. Usual occupation: house-wife
11. Industry or business
FATHER 12. Name: Eli Thomas Bennett
FATHER 13. Birthplace: Carroll Co. Md.
MOTHER 14. Maiden name: Georgeanna Hardon
MOTHER 15. Birthplace: Carrol Co. Md.
16. Informant: Charles B. Goodwin
Address: 117 Green St. Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 12 40 (month) (day) (year)
Cemetery ~~or crematory~~: Westminster Cem.
Location: Westminster Md.
18. Funeral director: J. E. Myers Jr.
Address: Westminster, Md.
19. 3/10 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10th 1940, at 2P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1st 1939, to Mar. 10th 1940, and that I last saw her alive on Mar. 9th 1940.

Immediate cause of death: Carcinoma of the Uterus — DURATION: Probably a year
Due to (Fibroid for at least 6 years from history)
Due to
Other conditions: None
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE C. J. Billingslea M. D. or other
Address Westminster, Md. Date signed 3/11/40

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02962

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 month 7 days
Stay in this community (yrs., or mos., or days): (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1410 Druid Hill Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Shannon Green

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

B (b) Name of husband or wife: Claudie Green
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 24, 1898

8. AGE: Years	Months	Days	If less than one day
41	9	6	hrs. min.

9. Birthplace: Glavaston, Texas (Town, county, and state)
10. Usual occupation: Mechanic
11. Industry or business: Stevenson Garage

FATHER
12. Name: Haidy Green
13. Birthplace: Charleston, S. C.

MOTHER
14. Maiden name: Cora Brown
15. Birthplace: Texas

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: May 5 1940 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location:
18. Funeral director: Adolphus Hartsock
Address: 918 Druid Hill Ave.

19. 3/1/40 (Date rec'd by registrar) 19 Albert R. Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1, 1940 19 , at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 23, 1940 19 , to March 1 19 40 , and that I last saw him alive on March 1, 1940 19

Immediate cause of death	Pulmonary Tuberculosis	DURATION Sept. 1938
Due to	--	
Due to	--	
Other conditions	---	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M. D.
M. D. or other
Address: Henryton, Md. Date signed: 3/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MAR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02963

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Hampstead Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Hampstead Near. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Carla Irene Gummel.

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married.

6 (b) Name of husband or wife Lewis A.C. Gummel.

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov 4 1879

8. AGE:

Years	Months	Days	If less than one day
60	4	0	hrs. min.

9. Birthplace Westminster Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

FATHER
12. Name J. Thomas Yingling
13. Birthplace Maryland.

MOTHER
14. Maiden name Louise Yakes.
15. Birthplace Maryland.

16. Informant Lewis A.C. Gummel.
Address Hampstead, Md.

17. Burial Date thereof March 7/40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Manchester

Location Manchester Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. Mar 5 1940 John S. Hughes. Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1940, at 6 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 1940, to March 4 1940, and that I last saw h-ew alive on March 4 1940.

Immediate cause of death	DURATION
Coronary Occlusion	?
Due to Chronic Myocarditis	?
Due to —	
Other conditions Chronic Cholecystitis	?

(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Sarah E. Buck. M.D.
M. D. or other

Address Hampstead Md Date signed 3/4/40

RECEIVED
APR 8 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02964

Reg. Dist. No. 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster - Rural

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) ~~2 mos~~ 7 Mos

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Frederick

City or town Frederick Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Goldie Marie Haines

3. (b) Social Security Number 214-10-2645

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27 - 1904

8. AGE:

Years	Months	Days	If less than one day
35	7	6	hrs. min.

9. Birthplace Frederick Co. Md.

(Town, county, and state)

10. Usual occupation Factory Worker

11. Industry or business Clothing

FATHER 12. Name Charles Wesley Haines

13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden name Emma May Fritz

15. Birthplace Frederick Co. Md.

16. Informant Mrs. Bertha Ruby

Address Westminster Md.

17. Mch. 6-1940 (Burial, ~~cremation, or removal~~. Which?) Date thereof Mch 6 '40 (month) (day) (year)

Cemetery or ~~crematory~~ Rocky Ridge Hill Cem

Location " " Md

18. Funeral director C. E. Clunet & Son

Address Frederick Md

19. 3/4 1940 (Date rec'd by registrar) J. L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4 1940, at 6.10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 29 1940, to Mar. 4 1940, and that I last saw her alive on Mar. 1 1940.

	DURATION
Immediate cause of death Acute Cardiac dilatation	about 8 hours
Due to Acute Myocarditis	about 6 weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas R Fout M D

M. D. or other

Address Westminster Date signed 3/4/40

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 75

CERTIFICATE OF DEATH

02965

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Rural - Roller, Md
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 15 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Carroll

(c) City or town Rural - Roller, Md
(If outside city or town limits, write RURAL and give town)

(d) Street No.
(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Martha Bell Hamner

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Calvin Hamner

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1851

8. AGE: Years 89 | Months 1 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Emmitsburg, Md
(Town, county, and state)

10. Usual occupation - Housework

11. Industry or business

FATHER

12. Name Andrew Jackson Shields

13. Birthplace Emmitsburg, Md

MOTHER

14. Maiden Name Unknown

15. Birthplace Emmitsburg Md

16 (a) Informant Mrs. Hester Shield (daughter)

(b) Address Millers, P.O., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-13-40 (month) (day) (year)

(c) Cemetery or crematory Cemetery

Location Middletown, Md.

18 (a) Funeral director Jas. T. Wantz's Sons

(b) Address Westminster, Md.

19 (a) Mar 17 40 (Date rec'd by registrar) (b) Mrs. M. L. Renner Registrar

MEDICAL CERTIFICATION

20. Date of death March, 10 1940, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1939, to March, 10 1940, and that I last saw him alive on March, 9 1940

Immediate cause of death	Duration
Carcinoma of Stomach	5 mo.
Due to	
Due to	
Other conditions Arteriosclerosis, General (Include pregnancy within 3 months of death)	years

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Maurice C. Partenheimer
M. D. or other

Address Hampstead Date signed 3/10/40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

02966

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County Carroll Co.
City or town Rural Near Westminster Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution: X
Stay in hospital or inst. (yrs., or mos., or days) X
Stay in this community (yrs., or mos., or days) 7yr + 6 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Near Westmin Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Cranberry Md.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR X

3. (a) FULL NAME George W. Harris

3. (b) Social Security Number X

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Martha V. Hunter
6(c) If alive, give age X years
7. Birth date of deceased (mo., day, yr.): Dec. 30th 1860
8. AGE: Years 79 | Months 2 | Days 8 | If less than one day ____ hrs. ____ min.
9. Birthplace: Marston Carroll Co. Md. (Town, county, and state)
10. Usual occupation: Blacksmith
11. Industry or business:
FATHER 12. Name: David Harris
13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret Hanes
15. Birthplace: Germany
16. Informant: Mrs. Joshua Hunter
Address: Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 9 40 (month) (day) (year)
Cemetery or crematory: Stone Chapel Cem.
Location: Near Westminster, Md.
18. Funeral director: J. E. Myers Jr.
Address: Westminster
19. 3/9 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 6th 1940, at 9 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1938, to Mar 6 1940, and that I last saw him alive on Feby. 28 1940.

	DURATION
Immediate cause of death: acute cardiac Dilatation	
Due to Arterio Sclerosis Chronic	about 6 W 8 ms
Due to Chronic Interstitial Nephritis	about 5 years
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations: no Operation
Of autopsy: no autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE Chas R. Foutz M.D. M. D. or other
Address Westminster Date signed 3/7/40

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

02967

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County Carroll Co.
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 174 E. Main St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) about 35 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll Co.
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 174 E. Main St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR X

3. (a) FULL NAME Lorraine Kemp Hoff

3. (b) Social Security Number X

4. Sex female

5. Color or race white

6. (a) Single, married, widowed, or divorced married

B (b) Name of husband or wife Ivan L. Hoff

6(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Feb. 15. 1874

8. AGE: Years 66 | Months 0 | Days 19 | If less than one day ____hrs. ____min.

9. Birthplace Littlestown Penna.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Dr. Joshua Kemp
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Susan Allgire
15. Birthplace Carroll Co. Md.

16. Informant Ivan L. Hoff
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 6 '40 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster Maryland

18. Funeral director J. E. Myers Jr.
Address Westminster, Md.

19. 3/7 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4th 1940, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1939, to Mar. 4th 1940, and that I last saw her alive on Mar. 1st 1940.

	DURATION
Immediate cause of death Metastases from a carcinoma of Breast	18 mos.
Due to Carcinoma of Breast	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma of Breast (Jan. 1939)
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE C. T. Billingslea M. D. or other
Address Westminster, Md. Date signed 3/5/40

RECEIVED
APR 4 1940
BUREAU V. S.

02968

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 111 E Green St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 111 E. Green
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Amos Melvin Horine

3. (b) Social Security Number none

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of ~~husband~~ or wife: Mabel Hess
6(c) If alive, give age: 62 years
7. Birth date of deceased (mo., day, yr.): Nov. 14 - 1860
8. AGE: Years 79 | Months 3 | Days 22 | If less than one day ___ hrs. ___ min.
9. Birthplace: Frederick Co. Maryland (Town, county, and state)
10. Usual occupation: Pharmacist
11. Industry or business
FATHER
12. Name: John A. Horine
13. Birthplace: Frederick Co. Md.
MOTHER
14. Maiden name: Frances Grove
15. Birthplace: Maryland
16. Informant: Randolf A. Horine
Address: Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 9. 1940 (month) (day) (year)
Cemetery or crematory: Burkittsville Cemetery
Location: Frederick Co. Maryland
18. Funeral director: H Bankard & Son
Address: Westminster Md.
19. 3/ 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1940, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1940, to March 6 1940, and that I last saw him alive on March 6 1940.
Immediate cause of death: Cardio Vascular Renal Disease c̄ Hypertension
Due to: Arteriosclerosis - Senility
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W Glenn Speicher M. D. or other
Address: Westminster Date signed: Mar 7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (I) (T) (M)

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

02969

(83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:
County Carroll
City or town Near Manchester Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 70-3-19

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Near Manchester Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME David H. Hosfeld

3. (b) Social Security Number None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Alice Hosfeld
6(c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.) Nov. 20, 1869
8. AGE: Years 70 | Months 3 | Days 19 | If less than one day ___ hrs. ___ min.
9. Birthplace Maryland, Carroll Co.,
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Andrew Hosfeld
13. Birthplace Germany
MOTHER
14. Maiden name Louise Rinehart
15. Birthplace Penna.
16. Informant Mrs. Alice Hosfeld
Address Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-22-40 (month) (day) (year)
Cemetery or crematory Cemetery
Location Manchester Md
18. Funeral director Jacob Wink's Sons
Address Manchester Md
19. Mar. 21 1940 Mrs W. R. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 19 1940, at 10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1939, to Mar 19 1940, and that I last saw him alive on Mar 19 1940.
Immediate cause of death Cerebral Hemorrhage — DURATION ?
Due to Arterio Sclerosis — ?
Due to Hypertension — ?
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W R S Denner
M. D. or other
Address Manchester Md Date signed 3/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02970

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carroll

City or town: Linebord

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insl. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): over 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Linebord Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Joshua Grason Hoshall

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6 (b) Name of husband or wife: Sarah Ellen

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 3, 1860

8. AGE: Years	Months	Days	If less than one day
79	5	13	hrs. min.

9. Birthplace: Balto. Co. (Town, county, and state)

10. Usual occupation: FARMER

11. Industry or business

FATHER

12. Name: Jacob Hoshall

13. Birthplace: Balto. Co.

MOTHER

14. Maiden name: Phoebe Fowble

15. Birthplace: Balto Co.

16. Informant: Fanny B. Hoshall

Address: Parkton Md.

17. (Burial, cremation, or removal. Which?) Date thereof: MAR. 19, 1940 (month) (day) (year)

Cemetery or crematory: Pine Grove Md.

Location: Rayville Md.

18. Funeral director: R. N. Seabert

Address: Freeland, Md.

19. Mar. 17 1940 (Date rec'd by registrar) Mrs. N. R. S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 16 1940, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1937, to Mar. 16 1940, and that I last saw him alive on Mar. 16 1940

Immediate cause of death	DURATION
Uremia secondary to	
Due to	
Due to	
Other conditions: generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. M. France M. D. or other

Address: Parkton, Md. Date signed: 3/17/40

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (838)

02971

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll.
City or town Sykesville Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or Inst. (yrs., or mos., or days) 2 days
Stay in this community (yrs., or mos., or days) 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 830 S. Hamilton St.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Theresa Hubbard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Unk

6 (b) Name of husband or wife Unk Charles Hubbard
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unk

8. AGE: Years	Months	Days	If less than one day
63? Unk			hrs. min.

9. Birthplace Unk Germany
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Unk
13. Birthplace Germany

MOTHER
14. Maiden name Unk
15. Birthplace Germany

16. Informant Hospital Records
Address Sykesville Md.

17. Burial Date thereof 3-20-40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Springfield Hosp. Cemetery
Location Sykesville, Md.

18. Funeral director C. Harry Lewis
Address Sykesville Md

19. 3-19-40 19 C Harry Lewis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 16 1940 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 14 1940, to Mar 16 1940, and that I last saw h er alive on Mar 16 1940.

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to Middle Cerebral artery	2 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy as above

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Max Hayman M. D. or other
Address Springfield State Hosp. Date signed 3/22/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Authorization to add items in red, letter in file under Dr. Beyer 4/8/40.
A.

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02972

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 5 Mos. 17 days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Royal Oak Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Annie Brummel Jenkins

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: Charles Henry Jenkins

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1889

8. AGE: Years	Months	Days	If less than one day
51	0	18	-- hrs. -- min.

9. Birthplace: Royal Oak, Md. (Town, county, and stete)

10. Usual occupation: Housewife

11. Industry or business: --

FATHER — 12. Name: Murray L. Brummel

FATHER — 13. Birthplace: Royal Oak, Md.

MOTHER — 14. Maiden name: Harriet Gibson

MOTHER — 15. Birthplace: Royal Oak, Md.

18. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-9-40 (month) (day) (year)

Cemetery or crematory: Easton

Location: Easton, Md.

18. Funeral director: John D. Williams

Address: Easton Md.

19. 3/6/40 (Date rec'd by registrar) 18. Deputy Local Registrar: Albert R. Swankhaus

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 19 40, at 5.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 18, 1939 19 to March 6, 1940 19 and that I last saw h er alive on March 6, 1940 19

Immediate cause of death	DURATION
Cardiac Failure	2 weeks
Due to: Bronchial Asthma	1938
Due to: Pulmonary Tuberculosis	Sept. 1934
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: no Autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)

Address: Henryton, Maryland Date signed: 3/6/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 9 1940
MILITARY A. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02973

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 7 Mos. 11 days
Stay in this community (yrs., or mos., or days): (Same as Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 531 N. Bond St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: James Norman Johnson

3. (b) Social Security Number: (1) 064-07-8284 (2) 215-05-0284

Poss.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Florence Johnson
6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): March 4, 1910

8. AGE: Years	Months	Days	If less than one day
30	0	2	____ hrs. ____ min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Griffin Johnson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Nancy Corbin
15. Birthplace: Virginia

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/10/40 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cem.
Location: B. C. County Md.

18. Funeral director: Joseph E. Locke, Jr.
Address: 1364 N. Central Ave.

19. 3/6/40 (Date rec'd by registrar) Albert R. Swanbaum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6, 1940 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24, 1939 to March 6, 1940
and that I last saw him alive on March 6, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	May 1939
Due to --	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ---
Of autopsy No autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Maryland Date signed 3/5/40

Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02974

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 day
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 929 N. Vincent St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Le Roy Johnson

3. (b) Social Security Number: 220-07-1701

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 19, 1919

8. AGE:

Years	Months	Days	If less than one day
20	3	8	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Porter

11. Industry or business: unknown

FATHER
12. Name: Michel Johnson
13. Birthplace: Essex County, Virginia

MOTHER
14. Maiden name: Lucy Byrd
15. Birthplace: Essex County, Virginia

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-31-40 (month) (day) (year)
Cemetery or crematory: Int. Calvary
Location: A. A. Co. Md.

18. Funeral director: Jas. M. Skinner
Address: 927 N. Mount St

19. 3/27/40 (Date rec'd by registrar) Albert R. Swackhamer Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27, 1940 19 , at 5:10 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27, 1940 to March 27, 1940 and that I last saw him alive on March 27, 1940

Immediate cause of death	Pulmonary Tuberculosis	DURATION 7 mos.
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: No autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 3/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 30 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02975

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 7 mo's 26 days

Stay in this community (yrs., or mos., or days): Above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1228 Mosher Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Lewis Johnson

3. (b) Social Security Number: 217-01-2622

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

B (b) Name of husband or wife: Ida Benns Johnson

6(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): July 4, 1908

8. AGE: Years	Months	Days	If less than one day
31	8	24	____ hrs. ____ min.

9. Birthplace: Remo, Va.
(Town, county, and state)

10. Usual occupation: Insurance Agent

11. Industry or business: Unknown

FATHER
12. Name: Frederick Johnson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Elizabeth Taylor
15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-4-40 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Cedar Hill Md.

18. Funeral director: Elroy O. Wilson

Address: 1005 E Brantley Ave

19. 3/30/40 (Date rec'd by registrar) Albert E. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION 2.27

20. DATE OF DEATH: March 30, 1940, at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4, 1940 to March 30, 1940 and that I last saw him alive on March 30, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1938
Due to ----	
Due to ----	
Other conditions ----	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations ----

Dt autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Md. Date signed 3/30/40

RECEIVED
APR 3 1940
V. S.

02976

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis San. (Colored)

Stay in hospital or inst. (yrs., or mos., or days) 2 mos.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1826 Ashland Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR --

3. (a) FULL NAME: Malachi Jordon

3. (b) Social Security Number: none

4. Sex: male

5. Color or race: colored

6. (a) Single, married, widowed, or divorced: married

B (b) Name of husband or wife: Isadora Jordon

6(c) If alive, give age 38 years

T. Birth date of deceased (mo., day, yr.) April 6, 1901

8. AGE: Years 38 | Months 11 | Days 17 | If less than one day ___ hrs. ___ min.

9. Birthplace Florence, S.C.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business --

FATHER
12. Name Boykin Jordon
13. Birthplace Florenec, S.C.

MOTHER
14. Maiden name Queen Victoria Benjamin
15. Birthplace Florence, S.C.

16. Informant Reuben Hoffman, M.D.
Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/24/40 (month) (day) (year)

Cemetery or crematory Florence S.C

Location S.C

18. Funeral director Byron & Mamie Wright
Address 1218 McCaldery

19. 3/23 (Date rec'd by registrar) 1940 Albert R. Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1940, at 5:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 23 1940, to March 23 1940, and that I last saw him alive on March 23 1940.

Immediate cause of death: Pulmonary tuberculosis — DURATION: 1933

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other
Address Henryton, Md. Date signed 2/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 28 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02977

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or insl. (yrs., or mos., or days): 7 months.
Stay in this community (yrs., or mos., or days): same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1217 West North Ave.,
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John M. Kehl.

3. (b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Widowed.

6 (b) Name of husband or wife: Bessie

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 22, 1872.

8. AGE: Years	Months	Days	If less than one day
68.	1.	0.	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Policeman,

11. Industry or business: Balto. City Police Dept.

FATHER 12. Name: Nicholas Kehl.

FATHER 13. Birthplace: Germany.

MOTHER 14. Maiden name: Eva Brickner.

MOTHER 15. Birthplace: Germany

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/25/40 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cemetery
Location: Belair Road Balto. Md.

18. Funeral director: George J. Ruth Inc.
Address: 1735 Harford Avenue.

19. Mar. 23 19 40 C. Harry Heer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22, 1940, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 23, 1939, to Mch. 22, 1940, and that I last saw him alive on Mch. 22, 1940.

Immediate cause of death	DURATION
Acute Broncho-Pneumonia	3-19-40
Due to	
Due to	
Other conditions: Cerebral Arterio-Sclerosis prior to 8-23-39.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M. D.
M. D. or other
Address: Sykesville, Md. Date signed: 3-22-40.

RECEIVED
MAR 28 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

02978

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 13 days
Stay in this community (yrs., or mos., or days) 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 313 S. Newkirk St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Agnes Krug

3. (b) Social Security Number

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced married
8 (b) Name of husband ~~or wife~~ John Thomas Krug
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) January 13, 1886

8. AGE: Years 54 Months 2 Days 2 If less than one day hrs. min.

8. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Joseph Kmieciak
13. Birthplace Poland
MOTHER 14. Maiden name Elizabeth Hoffman
15. Birthplace Poland.
18. Informant John Thomas Krug
Address 313 S. Newkirk St., Baltimore
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-19-40 (month) (day) (year)
Cemetery or crematory Balto Cemetery
Location North Ave
18. Funeral director John Ullrich
Address 2008 Orleans St
19. 3-15-40 (Date rec'd by registrar) 19 C Harry Weir Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1940, at 7:10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1940, to March 15 1940, and that I last saw her alive on March 15 1940.

Immediate cause of death Bronchopneumonia c̄ acute pleurisy. DURATION 8 days.
Due to
Due to
Other conditions General paresis
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Barbara J. Betz, M.D. M. D. or other
Address Springfield State Hospital Date signed March 15, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 21 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 13

02979

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Brahcn
Stay in hospital or insf. (yrs., or mos., or days) 2 Mos. 3 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 531 W. West St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Cordelia Lambert

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	C	Single

6 (b) Name of husband or wife --
6(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) March 24, 1927

8. AGE:

Years	Months	Days	If less than one day
12	11	29	hrs. min.

9. Birthplace New York, N. Y.
(Towo, county, and state)
10. Usual occupation Scholar
11. Industry or business Schalar

FATHER
12. Name Melvin Lambert
13. Birthplace Golston, N. C.

MOTHER
14. Maiden name Gladys Tuck
15. Birthplace Scranton, Pa.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 27, 1940 (month) (day) (year)
Cemetery or crematory
Location Sanford N. C.
18. Funeral director Joseph A. Lively
Address 419 N Mount St Baltimore md
19. 3/22/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1940 19 , at 11:05 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19, 1940 19 , to March 22, 1940, and that I last saw her alive on March 22, 1940 19

Immediate cause of death Pulmonary Tuberculosis — DURATION Dec. 1939
Due to --
Due to --
Other conditions ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations --
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide -- Date of --
Where did injury occur? --- (City or towo) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M. D. M. D. or other
Address Henryton, Md. Date signed 3/22/4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 3 1940
REAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

02980

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 86½ Penn. Ave.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 77

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. 86½ Penn. Ave. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Luther E. Long

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of ~~husband~~ or wife Florence Massicott Long 6(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Jan. 29 - 1862

8. AGE:

Years	Months	Days	If less than one day
78	1	22	hrs. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)

10. Usual occupation Railway Employe Ret.

11. Industry or business Laborer

FATHER 12. Name Abraham M. Long

13. Birthplace Maryland

MOTHER 14. Maiden name Johanna Rachael Dantz

15. Birthplace Maryland

16. Informant Mrs Florence Long

Address 86½ Penn. Ave. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 14-1940 (month) (day) (year)

Cemetery or crematory St Johns Catholic Cemetery

Location Westminster, Maryland

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. 3/13 1940 (Date rec'd by registrar) J. L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11th 1940, at 4a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Mar. 1st 1935, to Mar. 11th 1940, and that I last saw h— alive on Mar. 9th 1940.

	DURATION
Immediate cause of death Uremia Coma	2 days
Due to Cardio-Renal-Vascular Disease	10 yr.
Due to arteriosclerosis	10 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. H. Billingslea M. D. or other

Address Westminster, Md. Date signed 3/11/40

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-4

CERTIFICATE OF DEATH

02981

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Carroll.
County
City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 41 yrs, 11 mos, 17 days.
Stay in this community (yrs., or mos., or days) Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County
City or town Baltimore. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Unknown
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George W. Louis.

3. (b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Single.

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860.

8. AGE: Years	Months	Days	If less than one day
80.	Unk.	Unk.	hrs. min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual occupation Shoemaker.
11. Industry or business

FATHER
12. Name Charles F. Louis.
13. Birthplace Unknown.

MOTHER
14. Maiden name Unknown.
15. Birthplace Unknown.

16. Informant Springfield Hospital Record.
Address Sykesville, Md.

17. Burial Date thereof 3-13-40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Springfield Hosp. Cemetery
Location Sykesville Md.
18. Funeral director C. Harry Weed
Address Sykesville Md.

19. 3-12-40 19 C. Harry Weed
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1940, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1936, to Mch. 11, 1940, and that I last saw him alive on Mch. 11, 1940.

Immediate cause of death	DURATION
General Arteriosclerosis prior to 11-8-37.	
Due to	
Due to	
Other conditions Chronic Myocardial Degeneration about 2 years.	
(Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry F. Baer, M.D.
M. D. or other
Address Sykesville, Md. Date signed 3-11-40.

RECEIVED
APR 3 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186-a

02982

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Cassell Home of the Aged

Stay in hospital or inst. (yrs., or mos., or days) 13 years

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. W. Main
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Miss Elizabeth Rose Luman

3. (b) Social Security Number None

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1 1846

8. AGE: Years 93 Months 9 Days 27 If less than one day hrs. min.

9. Birthplace Cumberland Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Samuel Luman
13. Birthplace —

MOTHER
14. Maiden name ~~Jane~~ Scott
15. Birthplace —

16. Informant Mrs Millie Little

Address Cassell Home of the Aged Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 30, 1940 (month) (day) (year)

Cemetery or crematory Cumberland

Location Maryland

18. Funeral director H B Bankard & Son

Address Westminster, Maryland

19. 3/29 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1940, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4th 1940, to March 28th 1940 and that I last saw her alive on March 28th 1940.

Immediate cause of death: Hypostatic Pneumonia — DURATION: 3 days

Due to Fracture of hip — due to — 11 weeks

Due to an accidental fall; in her bedroom; at the Cassell Home for the Aged, Westminster, Maryland, December 16th, 1939

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Dec. 26, 1939

Where did injury occur? Westminster (City or town) Carroll (County) Md. (State)

Injured at home, farm, industry, public place (where?) the Cassell Home

Means of injury Accidental fall. Injured at work?

23. SIGNATURE [signature] M.D. (M. D. or other)

Address Westminster Md. Date signed 3/29/40

RECEIVED
APR 8 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

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T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

02983

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 6 days

Stay in this community (yrs., or mos., or days): 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 4100 Overlea Ave., Baltimore (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Sarah J. Mears

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or ~~wife~~: Mears

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): September 5, 1848.

8. AGE: Years: 91 Months: 6 Days: 11 If less than one day ____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James Mainley
13. Birthplace: Virginia

MOTHER
14. Maiden name: Agnes Ellers
15. Birthplace: Maryland.

16. Informant: George B. Mainley (Brother)

Address: 4100 Overlea Ave., Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-15-40 (month) (day) (year)

Cemetery or crematory: Parkwood Cemetery

Location: Balto

18. Funeral director: Fred. Lassahn

Address: 7401 Belair Rd Balto Md.

19. 3-16-40 (Date rec'd by registrar) 19 C Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1940, at 12:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11 1940, to March 16 1940, and that I last saw her alive on March 16 1940.

Immediate cause of death: Bronchopneumonia — DURATION: 2 days

Due to

Due to

Other conditions: Arteriosclerosis, general. Arteriosclerotic heart disease (Include pregnancy within 3 months of death)

Major findings: —

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Barbara J. Betz, M.D. (M. D. or other)

Address: Springfield State Hospital Date signed: Mar. 16, 1940

RECEIVED
APR 3 1940
BUREAU V. S.

02984

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH:
County Carroll
City or town Linwood
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 85-5-26

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carrol
City or town Linwood Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Caroline R. Messler

3. (b) Social Security Number

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced widow
6 (b) Name of husband or wife J. William Messler
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 25 - 1854

8. AGE: Years 85 Months 5 Days 26 If less than one day hrs. min.

9. Birthplace Carroll (Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Washington Senseney
13. Birthplace Md
MOTHER 14. Maiden name Mary Grimes
15. Birthplace Md
16. Informant Mrs Seward S. Englar
Address Linwood Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/24/40 (month) (day) (year)
Cemetery or ~~crematory~~ Church of God
Location Uniontown Md.
18. Funeral director C. Duss & Son
Address Taneytown, Md.
19. March 22 1940 (Date rec'd by registrar) Ernest S. Benchet Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22 1940, at 3a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 4 1940, to Mar 22 1940, and that I last saw her alive on Mar 12 1940.

Immediate cause of death Apoplexy
Due to
Due to
Other conditions
(Include pregnancy within 8 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE T. H. Legg M D M. D. or other
Address Union Bridge Date signed 3/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (M) (I) (T)

RECEIVED
APR 8 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02985

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium
Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 2 Mos., 6 days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 3215 McTeague St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William Moore

Corr. (1) 256-01-6286
(2) 220-05-4771

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

B (b) Name of husband or wife: Frances Moore

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): April 27, 1915

8. AGE: Years	Months	Days	If less than one day
24	10	9	hrs. min.

9. Birthplace: Camilla, Ga.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER
12. Name: William Moore, Sr.
13. Birthplace: Camilla, Ga.

MOTHER
14. Maiden name: Bertha Hawkins
15. Birthplace: Camilla, Ga.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 11-1940 (month) (day) (year)

Cemetery or crematory: Mt Zion Cemetery

Location: Balto. Md.

18. Funeral director: Kate R. Williams

Address: 322 N. Schroeder St

19. 3/7/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1940 19 , at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 30, 1939 19 , to March 7, 1940 19 ,

and that I last saw him alive on March 7, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Aug. 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 3/7/40

RECEIVED
MAR 14 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02986

Reg. Dist. No. 87

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural or Mt. Airy
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: R. D. Mt. Airy, Md.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: James A. Myers.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Married.

6 (b) Name of husband or wife: Alice V. Myers ??

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6, 1874

8. AGE: Years: 65 | Months: 9 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business

FATHER
12. Name: Dennis A. Myers
13. Birthplace: Maryland

MOTHER
14. Maiden name: Dottie Simms
15. Birthplace: Maryland

18. Informant: Mrs. Alice V. Myers
Address: Mt. Airy Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 30 1940 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: near Mt. Airy Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Mar. 28 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1940, at 1:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mch 26 1940, to Mch 27 1940, and that I last saw h sm alive on Mch 26 1940.

Immediate cause of death	DURATION
Lobar Pneumonia	4 dys
Due to Influenza	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. M. VanPoole M. D. or other
Address: Mt Airy Md Date signed 3-27-40

RECEIVED
APR 6 1940
BUREAU V. S.

02987

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Finksburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 1 yr. 8 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Robert Eugene Nickoles

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 17, 1938

8. AGE:

Years	Months	Days	If less than one day
1	8	17	____ hrs. ____ min.

9. Birthplace: Finksburg, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Edgar C. Nickoles
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elsie M. McClelland
15. Birthplace: Maryland

16. Informant: Edgar C. Nickoles
Address: Finksburg, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 3/7/40 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 3/6 1940 (Date rec'd by registrar) L. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1940, at 2:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1938, to Mar 5 1940, and that I last saw him alive on March 4 1940.

Immediate cause of death: Pneumonia (whooping cough - Myocarditis (acute)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ____ Date of

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jermette, M.D. M. D. or other

Address: Westminster Date signed: Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (I) (T) (M)

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

02988

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1yr., 10 mos.,

Stay in this community (yrs., or mos., or days): 1yr., 9 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimare Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2912 Brighton St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Emma E. Patterson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 27, 1850

8. AGE:

Years	Months	Days	If less than one day
89	4	17	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business

FATHER

12. Name: William Patterson ?

13. Birthplace ?

MOTHER

14. Maiden name: Mary ?

15. Birthplace ?

16. Informant: Alfred C. Patterson

Address: 2912 Brighton St, Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 19-1940 (month) (day) (year)

Cemetery or crematory: London Park

Location: Frederick Road

18. Funeral director: Wareann Leach

Address: 1217 St Paul Street

19. 3-15-40 (Date rec'd by registrar) 19 Harry Wm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15, 1940, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1938, to March 15, 1940, and that I last saw h alive on March 15, 1940.

Immediate cause of death	DURATION
Gangrene of left foot	4 da
Due to	
Due to Arterio Sclerosis	
Hypertension	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, ~~fill in the~~ following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed: Mar 15/40

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

02989

CERTIFICATE OF DEATH

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll.

City or town: Rural: Coves Corner.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 12 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll.

City or town: Rural - Coves Corner Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.D.: New Windsor. Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: Hallie D. Poole

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6 (b) Name of husband ~~or wife~~: William S. Poole

6(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): May 7, 1876

8. AGE:

Years	Months	Days	If less than one day
63	10	3	____ hrs. ____ min.

9. Birthplace: Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business

FATHER
12. Name: George Angel
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Alverta Dawsiffer
15. Birthplace: Maryland.

16. Informant: M. Earle Poole

Address: Westminster, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 12, 1940 (month) (day) (year)

Cemetery or crematory: Lingamore Cemty

Location: Unionville, Fred. Co. Md.

18. Funeral director: C.M. Walter

Address: Winfield Md.

19. Mar. 11 1940 (Date rec'd by registrar) C.M. Farver Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1940, at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2nd 1940, to March 10th 1940, and that I last saw her alive on March 10th 1940

Immediate cause of death	DURATION
Bulbar Poralysis	6 days
Due to High Blood Pressure and Chronic Nephritis	6 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. C. Stitely M.D.

Address: New Windsor Md. M. D. or other

Date signed: 3/11/40

RECEIVED
APR 27 1940
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

02990

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Colonial Avenue
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Colonial Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Andrew George Prell

3. (b) Social Security Number 212-10-0667

4. Sex M
5. Color or race W
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of ~~husband~~ or wife Birtie A. Selway Prell
6(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) Dec. 22 - 1889
8. AGE: Years 50 Months 2 Days 16 If less than one day ___ hrs. ___ min.
9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual occupation Plant Dept. Employee
11. Industry or business C. & P. Telephone Co. Baltimore
FATHER
12. Name Andrew John Prell
13. Birthplace Maryland
MOTHER
14. Maiden name Regina Hilldorfer
15. Birthplace Maryland
16. Informant Mrs Birtie Selway Prell
Address Colonial Ave. Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 11-1940 (month) (day) (year)
Cemetery or cremetory Loudon Park Cem. Baltimore
Location Maryland
18. Funeral director H Bankard & Son
Address Westminster Maryland
19. 3/9 1940 (Date rec'd by registrar) T K Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 8th 1940, at 11 15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about 4/1 1938 to 3/8 1940 and that I last saw him alive on 3/8 1940
Immediate cause of death Pulmonary Hemorrhage — DURATION 10 mins.
Due to Pulmonary Tuber - Mon
Due to Culosis — Lon 5 yrs
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE T K Woodward MD M. D. or other
Address Westminster Date signed 3/9/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 13 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02991

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days): 12 yrs., 9 mos., 2 days.
Stay in this community (yrs., or mos., or days): Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County:
City or town: Baltimore, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1702 William St.,
(If rural give LOCATION)
#
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Carl F. Repelius.

3. (b) Social Security Number: #

4. Sex: Male.

5. Color or race: White.

6. (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown.

8. AGE: Years: 45. Months: Unk. Days: Unk. If less than one day: hrs. min.

9. Birthplace: Maryland (?)
(Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business:

FATHER
12. Name: William Repelius.
13. Birthplace: Germany.

MOTHER
14. Maiden name: Emma Rick.
15. Birthplace: Germany.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-14-40 (month) (day) (year)
Cemetery or crematory: Springfield Cemetery
Location: Sykesville Md.

18. Funeral director: C. Harry Baer
Address: Sykesville Md.

19. 3-11-40 (Date rec'd by registrar) 19 C. Harry Baer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9, 1940, at 10:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1938, to Mch. 9, 1940, and that I last saw him alive on Mch. 9, 1940.

Immediate cause of death: Adeno-Carcinoma of Stomach (pylorus). — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

prior to 1-27-'40.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Harry F. Baer, M. D.
M. D. or other
Address: Sykesville, Md. Date signed 3-9-40.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 12 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02992

1. PLACE OF DEATH (93-d)

County Carroll Registration Dist. No. 79

Village or City Middleburg No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Daniel Taylor Reff.

(a) Residence: No. Middleburg St., Ward

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lavinia Reff.

6. DATE OF BIRTH (month, day, and year): Dec. 5. 1859

7. AGE: Years 80 | Months 3 | Days 21 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Dealer.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Cattle.

10. Date deceased last worked at this occupation (month and year): Mar. 16. 40

11. Total time (years) spent in this occupation: Life

12. BIRTHPLACE (city or town) (State or country): Maryland

FATHER

13. NAME: Wesley Reff.

14. BIRTHPLACE (city or town) (State or country): Maryland.

MOTHER

15. MAIDEN NAME: Elizabeth Taylor

16. BIRTHPLACE (city or town) (State or country): Maryland.

17. INFORMANT (Address): Cleveland Reff. Middleburg, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place: Bevan Dam near Johnsville, Md. Date: Mar. 28, 1940

19. UNDERTAKER (Address): Powell & Albaugh Woodsboro Md.

20. FILED: 3/27, 1940 Rhea S. Diller Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH: March (Month) 26 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Mar 18, 1940, to Mar 26, 1940

I last saw him alive on Mar 26, 1940, death is said to have occurred on the date stated above, at 2 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Chronic Myocarditis

Date of onset

Other Contributory Causes of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) H. M. H. Missley M. D.

(Address) J. Ainsville Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at **school** or at **home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(I)

(T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

Ruby Richardson

CERTIFICATE OF DEATH

02993

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 1 yr. 6 Mo. 9 da.

Stay in this community (yrs., or mos., or days): Above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1501 W. Saratoga Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Ruby Beatrice Richardson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife: ----

--- 6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.): Nov., 11, 1919

8. AGE: Years	Months	Days	If less than one day
20	3	27	___ hrs. ___ min.

9. Birthplace: Littleton, N. C.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unknown

FATHER
12. Name: George Richardson
13. Birthplace: Littleton, N. C.

MOTHER
14. Maiden name: Annie Richardson
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-13-40 (month) (day) (year)

Cemetery or crematory: Mt. Zion

Location: Mt. Winans A.A. Co Md

18. Funeral director: Mrs. K. R. Williams

Address: 322 N. Schroeder St.

19. 3/9/40 (Date rec'd by registrar) 19 Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9, 1940 19 11:00 P.M., at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 30, 1938 19 to March 9, 1940 19, and that I last saw her alive on March 9, 1940 19

Immediate cause of death: Pulmonary Tuberculosis

Due to: --

Due to: --

Other conditions: ---

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No autopsy

DURATION: June 1938

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: --- Date of: --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 3/9/40

RECEIVED
APR 9 1940
BUREAU V. S.

02994

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92E) tr

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 9 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Smithsburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ✓
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Janet Rowe

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Melvin Rowe

6(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.): February 12, 1912

8. AGE: Years: 28 Months: Days: 25 If less than one day: hrs. min.

9. Birthplace: Smithsburg, Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Thomas Koontz
13. Birthplace: Smithsburg, Md

MOTHER
14. Maiden name: Effie K. Brenner
15. Birthplace: Smithsburg, Md

18. Informant: Hospital Records

Address: Sykesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-11-40 (month) (day) (year)

Cemetery or crematory: Harbaugh

Location: South of Rouzerville Pa

18. Funeral director: Walter G. Grove

Address: Waynesboro Pa

19. 3-9-40 (Date rec'd by registrar) 19 Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1940, at 11:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 28 1940, to March 8 1940, and that I last saw her alive on March 8 1940.

Immediate cause of death: Chronic Endocarditis (Mitral Valve)

Due to

Due to

Other conditions: Diarrhea + Enteritis (Unspecified)
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: As above

DURATION: 2 wks.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. — M. D. or other

Address: Sykesville, Md Date signed: March 9-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02995

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Littlestown, PA. R. D. 1.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Littlestown, PA. R. D. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charlotte Lentz

3. (b) Social Security Number

4. Sex Female (Girl) | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18 1940

8. AGE: Years — | Months — | Days 3 | If less than one day hrs. min.

9. Birthplace Littlestown, PA. R. D. 1
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Oscar D. Lentz

FATHER 13. Birthplace Carroll Co. Maryland

MOTHER 14. Maiden name Mae Rinehart

MOTHER 15. Birthplace Pennsylvania

16. Informant Oscar D. Lentz

Address Littlestown Pa R.D.

17. Piney Creek Brethren Church Cem. Date thereof March 21 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Piney Creek Brethren Church Cem.

Location (Mar.) Taneytown, Md.

18. Funeral director H. M. Little & Son

Address Littlestown PA. Per R.A.L.

19. March 21 1940 Mary B. Wilt Deputy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1940, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1940 to March 21 1940, and that I last saw h-- alive on March 21 1940

	DURATION
Immediate cause of death Lobar pneumonia	and
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. S. Crouse M. D.
M. D. or other

Address Littlestown Pa Date signed 3/21/40

RECEIVED
APR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 30

02996

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 143 Penn. Ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 73

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 143 Penn. Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Frank T. Shaeffer

3. (b) Social Security Number none

4. Sex M
5. Color or race W
6. (a) Single, married, widowed, or divorced married

6 (b) Name of ~~husband~~ or wife Corrie Helm Shaeffer

6(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Jan. 5 — 1867

8. AGE: Years 73 Months 2 Days 1 If less than one day ___ hrs. ___ min.

9. Birthplace Westminster, Carroll, Maryland
(Town, county, and state)

10. Usual occupation Plumber + Hardware Store

11. Industry or business

FATHER
12. Name William H. Shaeffer
13. Birthplace md.

MOTHER
14. Maiden name Sarah Gursler
15. Birthplace md.

16. Informant Theodore F. Shaeffer
Address Westminster, Md.

17. Burial
(Burial, cremation, or removal, Which?)
Date thereof March 10-1940
(month) (day) (year)
Cemetery or crematory Kriders Cemetery
Location Nr. Westminster, Md.

18. Funeral director H Bankard & son
Address Westminster Md.

19. 3/8 19 40 [signature]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6th 1940, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Mar. 1st 1928, to Mar. 6th 1940, and that I last saw him alive on March 5th 1940.

Immediate cause of death Ruptured aneurysm of aorta

Due to Lues

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Dt operations
Dt autopsy

DURATION
~~at least~~ Few minutes
Discovered 12 yrs. ago

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Billingslea
M. D. or other
Address Westminster, Md. Date signed 3/7/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 4 1940
BUREAU Y.-S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

02997

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days): 2 mos 9 days
Stay in this community (yrs., or mos., or days): 2 mos 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Frederick
City or town: Myersville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
Emma F. Shepley

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Married

8 (b) Name of husband or wife: William S Shepley
6(c) If alive, give age: ~~Unk~~ 67 years

7. Birth date of deceased (mo., day, yr.): Nov 17, 1874

8. AGE:

Years	Months	Days	If less than one day
65	3	14	hrs. min.

9. Birthplace: Myersville Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Henry Rice
13. Birthplace: Frederick Cty Md

MOTHER
14. Maiden name: Katheryn Ambrose
15. Birthplace: Frederick Cty Md

16. Informant: Hospital Records
Address: Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 4 1940 (month) (day) (year)
Cemetery or crematory: St Paul's Lutheran
Location: Myersville, Md

18. Funeral director: J. Thos Little and Son
Address: Myersville Md.

19. 3-2-40 (Date rec'd by registrar) 19 C Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 2 1940, at 12 40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1939, to Mar 2 1940, and that I last saw her alive on Mar 2 1940.

Immediate cause of death: Chronic Myocarditis — DURATION: Aug 1939
Due to: Generalized Arterio-Sclerosis — years
Due to: Sclerosis
Other conditions: Psychosis with Cerebral Arteriosclerosis
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Max Hayman M. D. or other
Address: Springfield State Hosp. Date signed: 3/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02998

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 43 E. Main St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 75 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 43 E. Main St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Margaret E. Shunk

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife: J. Walter Shunk

6(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): December 25, 1855

8. AGE: Years	Months	Days	If less than one day
84	2	5	____ hrs. ____ min.

9. Birthplace: Uniontown, Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Samuel A. Anders

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary A. Shugh

15. Birthplace: Maryland

16. Informant: J. Walter Shunk

Address: Westminster, Md.

17. Burial (Bnrial, cremation, or removal. Which?) Date thereof 3/3/40 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

19. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 3/1 (Date rec'd by registrar) 19 40 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/1 1940, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/19 1940 to 3/1 1940

and that I last saw h[illegible] alive on 3/1 1940

Immediate cause of death	DURATION
Acute Lobar Pneumonia	15 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Walter Shunk M. D. or other

Address: Westminster Md. Date signed 3/1/40

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-a tr

02999

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: County Carroll.
City or town Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days) 11 yrs., 6 mos., 22 days.
Stay in this community (yrs., or mos., or days) Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Howard.
City or town Rural. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No record.

3. (a) FULL NAME Reas Page Simpson.

3. (b) Social Security Number

4. Sex: Male.
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single.
6 (b) Name of husband or wife
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) March 27, 1861.
8. AGE: Years 78. Months 11. Days 9. If less than one day ____ hrs. ____ min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Laborer.
11. Industry or business General farm work.
FATHER 12. Name R. P. Simpson.
13. Birthplace Howard County, Md.
MOTHER 14. Maiden name Sarah Elizabeth Mask.
15. Birthplace West Virginia.
16. Informant Springfield Hospital Record.
Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-13-40 (month) (day) (year)
Cemetery or crematory Springfield Hosp. Cemetery
Location Sykesville Md.
18. Funeral director C. Harry Weer
Address Sykesville Md.
19. 3-12-40 19 ____ C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1940, at 1.50 p. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1938, to Mch. 9, 1940, and that I last saw him alive on Mch. 9, 1940.

	DURATION
Immediate cause of death: Cerebral Haemorrhage	3-9-40.
Due to: Cerebral Arterio-sclerosis prior to 8-16-28.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry F. Baer, M.D., M. D. or other
Address Sykesville, Md. Date signed 3-9-'40.

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03000

CERTIFICATE OF DEATH

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural nr Taylorsville, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: R.D. Westminster. Md
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Smith.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 26, 1940

8. AGE: Years | Months | Days | If less than one day: 3 hrs. min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name:
13. Birthplace:

MOTHER
14. Maiden name: Ruth Smith
15. Birthplace: Maryland

16. Informant: Ruth Smith
Address: R.D. Westminster. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 29, 1940 (month) (day) (year)
Cemetery or crematory: Taylorsville Cemty.
Location: Taylorsville, Carroll Co. Md.

18. Funeral director: C.M. Waltz
Address: Winfield. Md.

19. Mar. 29 1940 (Date rec'd by registrar) C.M. Farver Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1940, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 26 1940 to Mar 26 1940, and that I last saw h~~im~~ alive on Mar 26 1940.

Immediate cause of death	DURATION
Congenital Atelectasis	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: Jas. T. Round M.D.
M. D. or other
Address: New Windsor Md Date signed 3/29/40

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APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03001

940

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:

County Carroll

City or town Nr. Mayberry
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 65

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Ida L. Spangler

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife John C. Spangler

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1871

8. AGE: Years	Months	Days	If less than one day
69	1	11	hrs. min.

9. Birthplace Carroll County
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Jesse Fleagle

13. Birthplace Md.

MOTHER 14. Maiden name Mary Nusbaum

15. Birthplace Md.

16. Informant Mary I. Spangler

Address Westminster. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 29, 1940 (month) (day) (year)

Cemetery or crematory Reformed

Location Taneytown

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. Mch 27 1940 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1940, at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on See Note 19 .

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M. D.
M. D. or other

Address Taneytown Date signed 3/27/40

over

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Note:- This patient was not seen prior to death. The diagnosis was made on the basis of history and post-mortem examination.
March 27, 1940. R. S. McVaugh M. D.

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APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03002

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll Co.
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: 25 Park Ave.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 42 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll Co.
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 25 Park Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR X

3. (a) FULL NAME Nettie Jones Starr

3. (b) Social Security Number None X

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Rev. Jesse C. Starr
X 6(c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) Nov. 26 1854

8. AGE: Years	Months	Days	If less than one day
85	4	2	hrs. min.

9. Birthplace Mt. Marys Co. Md.
(Town, county, and state)
10. Usual occupation invalid
11. Industry or business

FATHER
12. Name Stephen Jones
13. Birthplace Maryland

MOTHER
14. Maiden name Mary F. Posey
15. Birthplace Maryland

16. Informant Mrs. Edward Little
Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 31 40 (month) (day) (year)
Cemetery or crematory Westminster, Cemetery
Location Westminster, Md.
18. Funeral director J. E. Myers Jr.
Address Westminster, Md.
19. 3/29 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/28 1940, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/26 1940, to 3/28 1940, and that I last saw h alive on 3/28 1940.

Immediate cause of death	DURATION
Lobar Pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Shelton Bon M.D.
M. D. or other
Address Westminster Md. Date signed 3/29/40

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APR 4 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (938)

03003

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 yrs., 4 mos., 17 days

Stay in this community (yrs., or mos., or days): 2 yrs., 4 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore City

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2209 Osuego Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Katie Steinberg

3. (b) Social Security Number:

4. Sex	5. Color or race	B. (a) Single, married, widowed, or divorced
Female	White	Married

B (b) Name of husband or wife: Jacob Steinberg

B(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): About 1870

8. AGE: Years	Months	Days	If less than one day
About 70			hrs. min.

9. Birthplace: Austria
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: ? Munder
13. Birthplace: Austria

MOTHER
14. Maiden name: ?
15. Birthplace: Austria

16. Informant: Joseph Kempler, son
Address: Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-4-40 (month) (day) (year)

Cemetery or crematory: Herring Run Cem.

Location:

18. Funeral director: Jack Levi Inc.
Address: 848 E. Baltimore

19. 3-2-40 (Date rec'd by registrar) 19 Harry Wm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1940, at 3:15 AM.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14, 1939, to March 2 1940, and that I last saw her alive on March 1 1940

Immediate cause of death	DURATION
Influenza, with Pneumonia Complicating	6 days
Due to	3 days
Due to	
Other conditions: Hypertensive cardiovascular disease	2 yrs. (Known)

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed 3-2-40

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (13-a)

03004

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Finksburg (Rural)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Finksburg (Rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Finksburg - Westminster Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George Hannibal Stockdale

3. (b) Social Security Number None.

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married.
6 (b) Name of husband or wife Margaret Wrighton Stockdale
6(c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) May 22. 1871
8. AGE: Years 68 Months 10 Days 6 5 If less than one day ___ hrs. ___ min.
9. Birthplace Finksburg - Carroll Co. Md. (Town, county, and state)
10. Usual occupation Minister
11. Industry or business Methodist Protestant Church.
FATHER
12. Name John Thomas Stockdale
13. Birthplace Finksburg Carroll Co. Md.
MOTHER
14. Maiden name Mary Benson.
15. Birthplace Virginia.
16. Informant Mrs. G. H. Stockdale
Address Finksburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 30-40 (month) (day) (year)
Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.
18. Funeral director D. D. Hartler & Sons.
Address Union Bridge Md
19. 3/24/40 (Date rec'd by registrar) 19 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 27th 1940, at 2 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Apr. 1st 1938, to Mar. 27th 1940, and that I last saw him alive on Mar. 26th 1940.
Immediate cause of death Uremia Coma — DURATION 2 days
Due to Cardio-Renal-Vascular Sclerosis — 2 years
Due to Chronic Myocarditis — 2 yrs
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Billingslea M. D. or other
Address Westminster, Md. Date signed 3/27/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

03005

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 49 Liberty St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 24 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 49 Liberty St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR X

3. (a) FULL NAME Carrie Virginia Stouer

3. (b) Social Security Number X None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6 (b) Name of husband or wife Edwin E. Stouer

6(c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) Jan. 18 1859

8. AGE:

Years	Months	Days	If less than one day
81	2	1	hrs. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)

10. Usual occupation house-wife

11. Industry or business

FATHER

12. Name John B. J. Sellman

13. Birthplace Maryland

MOTHER

14. Maiden name Savilla Hartzoch

15. Birthplace Maryland

16. Informant Mrs. Weldon Duvall

Address 49 Liberty St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 20 40 (month) (day) (year)

Cemetery or crematory Stone Chapel Cem.

Location near Westminster, Md.

18. Funeral director J. E. Myers Jr.

Address Westminster Md.

19. 3/[illegible]/40 [illegible] Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1940, at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1939, to Mar 17 1940, and that I last saw her alive on Mar. 16 1940.

	DURATION
Immediate cause of death Heart failure	
Due to arteriosclerotic disease and	8 mos.
Due to myocarditis	2 years
Other conditions arteriosclerotic kidneys. Senile dementia	2 years

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. Reese Wilkens M. D. or other

Address Westminster Date signed Mar 18 1940

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93-d)

03006

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 80 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: rural near Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: James M. Storms

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife: Katherine Beiker
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 8, 1859

8. AGE: Years	Months	Days	If less than one day
80	9	10	____ hrs. ____ min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)
10. Usual occupation: Railroad labor (retired)
11. Industry or business

FATHER
12. Name: Jacob L. Storms
13. Birthplace: Maryland

MOTHER
14. Maiden name: Not known
15. Birthplace: Not known

16. Informant: Roy E. Storms
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/20/40 (month) (day) (year)
Cemetery or crematory: Leister's Cemetery
Location: near Westminster

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 3/18 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18, 1940, at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Had not attended him recently 19__ to 19__
and that I last saw him alive on Just died Mar 18 1940

	DURATION
Immediate cause of death: acute cardiac Dilatation	30 minutes
Due to: arterio sclerosis	5 yrs
Due to: Chronic myocarditis	8 yrs
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: Chas R Foutz M.D.
M. D. or other
Address: Westminster Md Date signed 3/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131-P

03007

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll.

City or town Hampstead, Maryland. (Near.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland. County Carroll.

City or town Near Manchester Maryland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME ANNIE Mary Streveig.

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Henry E. Streveig.

6(c) If alive, give age Dead. years

7. Birth date of deceased (mo., day, yr.) Feb 6, 1858

8. AGE:

Years	Months	Days	If less than one day
82.	1	5	——hrs. ——min.

9. Birthplace Manchester, Carroll Co. Maryland.
(Town, county, and state)

10. Usual occupation House wife.

11. Industry or business Home.

FATHER
12. Name William Keefer.
13. Birthplace Maryland.

MOTHER
14. Maiden name Mary Sherman.
15. Birthplace Maryland.

16. Informant Irvin G. K. Streveig

Address Hampstead, Maryland.

17. Burial Date thereof 3-14-40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Manchester Md

18. Funeral director Jacob Wriki & Sons

Address Manchester Md.

19. Mar 13 1940 Mrs. W. R. S. Donner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1940, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1939, to March 11 1940, and that I last saw her alive on March 10 1940.

Immediate cause of death	DURATION
Chronic interstitial Nephritis	?
Due to Hypertensive Cardio-vascular Disease.	?
Due to Generalized Arterio-sclerosis.	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work?

23. SIGNATURE Jacob E. Buck M.D.
M. D. or other

Address Hampstead Md. Date signed 3/11/40

RECEIVED
APR 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03008

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatoriun Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 5 mos., 21 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1202 Rutland Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Dolores Mae Strickland

3. (b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1930

8. AGE:

Years	Months	Days	If less than one day
9	4	11	hrs. min.

9. Birthplace Nashville, N. C. (Town, county, and state)

10. Usual occupation scholar

11. Industry or business ---

FATHER
12. Name William Richardson
13. Birthplace Littleton, N.C.

MOTHER
14. Maiden name Peggy Quarrell
15. Birthplace Littleton, N. C.

16. Informant Dr. Rebuen Hoffman
Address Henryton, Maryland

17. Disposition (Burial, cremation or removal. Which?) Date thereof 3/29/40 (month) (day) (year)
Cemetery or crematory
Location Rocky Mount N. C.

18. Funeral director Roberts Funeral Home
Address 804 W. Carleine St.

19. 3/27/40 19 (Date rec'd by registrar) Albert R. Swankhaus Deputy Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1940 19 , at 2:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 6, 1939 19 to March 27, 1940 19 , and that I last saw her alive on March 27, 1940 19

Immediate cause of death	DURATION
Pulmonary tuberculosis	June 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy no autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) -- (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Rebuen Hoffman M.D.
M. D. or other
Address Henryton, Maryland Date signed 3/27/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03009

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 7 mos., 19 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1345 N. Carey St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ruth Tarlton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1923

8. AGE:

Years	Months	Days	If less than one day
17	1	18	hrs. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Scholar

11. Industry or business

FATHER
12. Name Richard Thomas
13. Birthplace unknown

MOTHER
14. Maiden name Margaret Tolton
15. Birthplace Baltimore, Md.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1 1940 (month) (day) (year)
Cemetery or crematory Mt. Auburn
Location Baltimore City
18. Funeral director Thomas E. Kelson
Address 1303 Presstman St.

19. 3/29/40 19 (Date rec'd by registrar) Albert R. Swanborn Deputy Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1940 19 5:30 A.M. at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 10, 1939 19 to March 29, 1940
and that I last saw her alive on March 29, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1939

Due to --

Due to --

Other conditions --

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy No autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman M. D.
M. D. or other
Address Henryton, Maryland Date signed 3/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 9 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

George Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03010

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 23 days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 804 Pierce St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: ~~George Theodore~~ Thomas, George Theodore

3. (b) Social Security Number: ~~Unknown~~ Loss: 216-10-6916

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Sept. 17, 1903

8. AGE: Years 26 | Months 5 | Days 22 | If less than one day: hrs. min.

9. Birthplace: Prince George Co., Md.
(Town, county, and state)

10. Usual occupation: Musician

11. Industry or business: Unknown

FATHER
12. Name: William Thomas
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof: March 15 1940 (month) (day) (year)

Cemetery or crematory: Prince George Co Md

Location: Same

18. Funeral director: Joseph A. Lively

Address: 409 N Mount St Baltimore city Maryland

19. 3/10/40 (Date rec'd by registrar) 19 Deputy Local Registrar: Albert R. Swankhouse

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10, 1940 19 , at 5;45 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 16, 1940 19 , to March 10, 19 1940 and that I last saw him alive on March 10, 1940 19

Immediate cause of death: Pulmonary Tuberculosis

Due to: --

Due to: --

Other conditions: ---
(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No Autopsy

DURATION: Jan. 1940

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 3/10/40

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03011

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 2 yrs, 2 Mos. 6 Da

Stay in this community (yrs., or mos., or days): (Same as above)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No. or a: 611 Poplar Hill Ave. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: --

3. (a) FULL NAME: Iris Picola Thomas

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife: --

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Nov. 22, 1920

8. AGE:

Years	Months	Days	If less than one day
19	3	11	____ hrs. ____ min.

8. Birthplace: Princess Anne, Md. (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: --

FATHER

12. Name: Leonard Thomas

13. Birthplace: Virginia

MOTHER

14. Maiden name: Mary Barkley

15. Birthplace: Maryland

18. Informant: Reuben Hoffman, M. D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-10-40 (month) (day) (year)

Cemetery or crematory: Johns Wesley

Location: Princess Anne, Md.

18. Funeral director: Wm. James

Address: Princess Anne, Md.

19. 3/5/40 (Date rec'd by registrar) 19__ Albert R. Swanbourne Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1940 19__, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/27/37 19__, to 3/5/40 19__, and that I last saw her alive on 3/5/40 19__.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Oct. 1937

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: No Autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other

Address: Henryton, Maryland Date signed: 3/5/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
APR 3 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

03012

1. PLACE OF DEATH

County Carroll Registration Dist. No. 76

Village or City Oakland No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Baby Thompson If U. S. Veteran, specify WAR no

(a) Residence: No. Oakland Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Sing

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of no

6. DATE OF BIRTH (month, day, and year)

7. AGE Years Still Born 5 mo Months Mar Days 31 If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Infant

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Carroll Co (State or country)

FATHER

13. NAME Wm. T. Thompson

14. BIRTHPLACE (city or town) Carroll Co (State or country)

MOTHER

15. MAIDEN NAME Eleanor Ellis

16. BIRTHPLACE (city or town) Chambersburg Pa (State or country)

17. INFORMANT Wm. T. Thompson (Address) Lighesville

18. BURIAL, CREMATION, OR REMOVAL

Place New Oakland Cem Date 3/31, 1940

19. UNDERTAKER Wm. T. Thompson (Address) Sykesville Md

20. FILED 3/31, 1940 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March (Month) 31st (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Still Born, 19___, to ___, 19___

I last saw h___ alive on ___, 19___; death is said to have occurred on the date stated above, at 5 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Still Born 5 mo	

Other Contributory Causes of importance:

Name of operation ___ Date of ___

What test confirmed diagnosis? ___ Was there an autopsy? ___

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased? ___

If so, specify ___

(Signed) [signature] M. D.

(Address) [illegible]

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED
APR 4 1928
BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(940)

03013

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Oakland Mills, Route 1 Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 36 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Oakland Mills, Sykesville Route 1 Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Oakland Road.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME John Robert Tracey.

3. (b) Social Security Number 213-01-9003.

4. Sex Male

5. Color or race White

6. (a) ~~Single, married, widowed, or divorced~~ Married

6 (b) Name of husband or wife Mary Elizabeth Kidwell Tracey

6(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1875

8. AGE: Years 65 Months 2 Days 1 If less than one day ____ hrs. ____ min.

9. Birthplace Balto. County.

(Town, county and state)

10. Usual occupation Retired cloth worker

11. Industry or business Oakland Woolen Mills

FATHER

12. Name Jarrett Tracey

13. Birthplace Md.

MOTHER

14. Maiden name Isabelle Duse

15. Birthplace Md.

16. Informant Mrs. John R. Tracey.

Address Oakland Mills Carroll Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5, 1940 (month) (day) (year)

Cemetery or ~~crematory~~ St. Pauls Cemetery

Location Hanover Road, Arcadia.

18. Funeral director Wm. Berryman & Sons.

Address Reisterstown, Md.

19. Mar 2 1940 C. Harry Weer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 2 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20th 1940, to Mar. 2 1940, and that I last saw him alive on Mar. 2, 1940.

Immediate cause of death Coronary thrombosis

Due to Cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other

Address Randallstown Date signed 3/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03014

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 20 days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1619 Druid Hill Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Clifton Garrett Tucker

3. (b) Social Security Number: 216-07-8405

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1897

8. AGE: Years	Months	Days	If less than one day
43	0	10	---hrs. ---min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Presser

11. Industry or business: Unknown

FATHER — 12. Name: George Tucker
FATHER — 13. Birthplace: Capetown, Md.

MOTHER — 14. Maiden name: Rachel Levers
MOTHER — 15. Birthplace: Calvert Co., Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Mar 5, 1940 (month) (day) (year)
Cemetery or crematory: City Morgue
Location: Balto. Md.

18. Funeral director: Mrs Samuel Hemsley
Address: 578 N. Biddle St.

19. 3/3/40 (Date rec'd by registrar) Deputy Local Registrar: Albert R. Swankhaus

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3, 1940 10:00 P.M. 19---, at ---M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12, 1940 19--- to March 3, 1940 19---, and that I last saw him alive on March 3, 1940 19---.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1939
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. (M. D. or other)
Address: Henryton, Md. Date signed 3/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 3 1980
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

03609

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Do not know County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Unknown (Stillborn)

3. (b) Social Security Number

4. Sex ?

5. Color or race W

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Westminster (probably)
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name not known
13. Birthplace

MOTHER
14. Maiden name Not known
15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ------ 19 , to ------ 19 ,

and that I last saw h alive on 19

Immediate cause of death Stillborn

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide XXXX Date of

Where did injury occur? XXXX (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jas. T. Marsh Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 5/10/40

St.11b . B.

RECEIVED
MAY 13 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03015

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 141 Bishop St
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 70 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Mary E. Utermahlen
3. (b) Social Security Number none

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced widow
6 (b) Name of husband or wife John Utermahlen
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 18, 1861

8. AGE: Years 78 Months 10 Days 1 If less than one day hrs. min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Frederick Wagner
13. Birthplace Md
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Mrs Ernest Helwig
Address Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 22 40 (month) (day) (year)
Cemetery or crematory Pleasant Valley
Location Pleasant Valley Md
18. Funeral director C O Duss & Son
Address Taneytown Md
19. 3/19 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1940, at 3:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 1940, to Mar 19 1940, and that I last saw her alive on Mar 18 1940.

Immediate cause of death Carcinoma Cardiac end of Stomach, Hemorrhage — DURATION 1½ mo.
Due to
Due to
Other conditions Arteriosclerosis Secondary Anemia
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other
Address Westminster Md Date signed Mar 19

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

03016

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 75 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Taneytown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth C.Wantz

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Franklin H.Wantz

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23,1860

8. AGE:

Years	Months	Days	If less than one day
79	5	7	hrs. min.

9. Birthplace Md

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER

12. Name Frederick Dern

13. Birthplace Md.

MOTHER

14. Maiden name Mary J.Koons

15. Birthplace Md

16. Informant Charles L.Wantz

Address Taneytown,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar.3,1940 (month) (day) (year)

Cemetery or crematory Lutheran

Location Harney,Md.

18. Funeral director C.O.FUSS & SON

Address Taneytown,Md.

19. Mar. 3, 1940 (Date rec'd by registrar) Ethel M Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12t 1940, at 7.45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25-th 1940, to Mar 12t 1940, and that I last saw h-s alive on Mar 12t 1940.

Immediate cause of death Cerebral Hemorrhage — DURATION 5 mins

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

20 operations

20 autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Benner MD M. D. or other

Address Taneytown Md Date signed 3/2/40

RECEIVED
APR 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (30-) tc

03017

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll.
City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital.
Stay in hospital or inst. (yrs., or mos., or days): 4 yrs., 4 mos., 8 days.
Stay in this community (yrs., or mos., or days): Same.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Washington.
City or town: Hagerstown. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 327 North Mulberry.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Guy William Wassen.

3. (b) Social Security Number: Post # 214-09-3950

4. Sex: Male.
5. Color or race: White.
6. (a) Single, married, widowed, or divorced: Married.
8 (b) Name of husband or wife: Lillian Whitzle.
6(c) If alive, give age: 43 years
7. Birth date of deceased (mo., day, yr.): August 10, 1894.

8. AGE: Years: 45. Months: 7. Days: 13. If less than one day: hrs. min.

9. Birthplace: Washington Co., Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business: Hagerstown Table Works.

FATHER
12. Name: John Henry Wassen.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Elizabeth Dennis.
15. Birthplace: Maryland.

16. Informant: Springfield Hospital Record.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 2, 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown Md

18. Funeral director: Scott F Minnich & Son
Address: Hagerstown Md.

19. 3-24-40 (Date rec'd by registrar) 19 C. Harry Weir (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23, 1940, at 10 30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15, 1935, to Mch. 23, 1940, and that I last saw him alive on Mch. 23, 1940.

Immediate cause of death: General Paralysis of the Insane prior to 11-15-35.
DURATION

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Harry F. Baer, M. D., M. D. or other
Address: Sykesville, Md. Date signed: 3-23-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 9 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03018

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
Maryland Tuberculosis San.(Col.)

Stay in hospital or insf. (yrs., or mos., or days) 2 mos., 7 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County ~~Carroll~~

City or town ~~Henryton~~ Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1436 E. Orleans St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR --

3. (a) FULL NAME Charles Wiggins

3. (b) Social Security Number 215-07-1561

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6 (b) Name of husband or wife --

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1897

8. AGE: Years	Months	Days	If less than one day
43	0	1	hrs. min.

9. Birthplace Raleigh, N.C.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Harmon Wiggins

13. Birthplace Unknown

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant Reuben Hoffman, M.D.

Address Henryton, Md.

17. X (Burial, cremation, or removal. Which?) Date thereof 3 6 40 (month) (day) (year)

Cemetery or crematory Mt Calvary

Location Anne Arundel County

18. Funeral director R.A. Elliott

Address 1129 N. Carolina St.

19. March 3 1940 (Date rec'd by registrar) Albert R. Swankhaus Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1940 19 --, at 7:50 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26 1939, to March 3 1940, and that I last saw him alive on March 3 1940

Immediate cause of death Pulmonary tuberculosis — DURATION: Began Oct. '39

Due to --

Due to --

Other conditions --

(Include pregnancy within 3 months of death)

Major findings:

Of operations --

Of autopsy --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
M. D., or other

Address Henryton, Md. Date signed 3/3/40

Authorization for residence: Tuberculosis follow-up card at Baltimore City Health Department 5/17/40 a.c.

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03019

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 2 years, 3 mos.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ervin Joseph Williams

3. (b) Social Security Number: (1) 437-07-6399 (2) 347-09-4514

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 29, 1914

8. AGE: Years: 25 | Months: 8 2 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: Havre de Grace (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Earl Williams

13. Birthplace: 829 Wallston St.; Wil., Del.

MOTHER

14. Maiden name: Madeline Williams

15. Birthplace: Same

16. Informant: Dr. Reuben Hoffman

Address: Henryton

17. Burial (Burial, cremation, or removal? Which?) Date thereof 3/31/40 (month) (day) (year)

Cemetery or crematory: Skinner's Cemetery

Location: Havre de Grace, Md.

18. Funeral director: Elmer E. Bullock

Address: Havre de Grace, Md.

19. 3/28/40 (Date rec'd by registrar) Albert R. Swandhaus Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28, 1940 19 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 31, 1937 19 to March 28, 1940, and that I last saw h im alive on March 28, 1940 19

	DURATION
Immediate cause of death: Tuberculous Meningitis	1 week
Due to: Pulmonary Tuberculosis	1937 to 1940
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings: --

Of operations:

Of autopsy: No autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Maryland Date signed: 3/28

RECEIVED
APR 9 1910
BUREAU V. S.

03020

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-B

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH:

County Carroll

City or town M. Gist

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 45 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural M. Gist Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.D. Sykesville, Md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No.

3. (a) FULL NAME Mrs. Ursula Wilson

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married.

6 (b) Name of husband ~~or wife~~ Samuel Wilson

6(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) May 18, 1871

8. AGE: Years 68 Months 9 Days 19 If less than one day ____ hrs. ____ min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation House work.

11. Industry or business

FATHER 12. Name John W. Shipley

13. Birthplace Maryland.

MOTHER 14. Maiden name Eliza A. Shipley.

15. Birthplace Maryland.

16. Informant Mr. Samuel Wilson

Address R.D. Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 10, 1940 (month) (day) (year)

Cemetery or crematory Harmony Grove

Location Gist, Carroll Co. Md.

18. Funeral director C.M. Waltz

Address Winfield, Md.

19. March 9 1940 (Date rec'd by registrar) Elva M. Hewitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1940, at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1939, to Mar. 7 1940, and that I last saw her alive on Mar. 7 - 40 19

Immediate cause of death Cancer of stomach Hypertension

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jarmette M.D. M. D. or other

Address Westminster Md. Date signed 3-7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(1940)

03021

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Rural nr. Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 3 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Carroll.
City or town Rural. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R.D. Sykesville, Md.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR no.

3. (a) FULL NAME Fuller R. Wright.

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed.
6 (b) Name of husband or wife: Late Mary C. Wright.
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): April 19 1855
8. AGE: Years 84 | Months 11 | Days 8 | If less than one day ____ hrs. ____ min.
9. Birthplace: Baltimore City. Maryland. (Town, county, and state)
10. Usual occupation: Blacksmith (Retired)
11. Industry or business
FATHER 12. Name: John Wright
13. Birthplace: Maryland.
MOTHER 14. Maiden name: Annie Fuller
15. Birthplace: Maryland.
18. Informant: Mrs. Annie McDonald.
Address: R.D. Sykesville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 29, 1940 (month) (day) (year)
Cemetery or crematory: Jennings Chapel
Location: Florence, Md.
18. Funeral director: C.M. Waltz
Address: Winfield Md
19. 3-28-1940 (Date rec'd by registrar) C. Harry Wine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1940, at 4:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1936 to 3/27 1940, and that I last saw him alive on 3/26 1940.

	DURATION
Immediate cause of death: Senility —	
arteriosclerosis	
Due to Myocarditis	
Due to Bronchitis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W.H. Lawson, M.D.
M. D. or other
Address Sykesville, Md. Date signed 3/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(52b)

03022

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Carroll St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Carroll St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Florence Ada Yingling
3. (b) Social Security Number: None

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: Fred G. Yingling
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): March 1 1869
8. AGE: Years 71 | Months 0 | Days 18 | If less than one day ____ hrs. ____ min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: House work
11. Industry or business: None
FATHER
12. Name: James H Myers
13. Birthplace: Maryland
MOTHER
14. Maiden name: Sarah E Whitmore
15. Birthplace: Maryland
16. Informant: Miss Ida Yingling
Address: Westminster Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 22-1940 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Silver Run St Mathew
18. Funeral director: C O Fuss & Son
Address: Taneytown Md
19. 3/21/40 (Date rec'd by registrar) 19 O R Fogle Registrar
Dep-Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-19-1940, at 11:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb-1st 1940, to Mar. 19 1940, and that I last saw her alive on Mar. 19-40 19

Immediate cause of death: Carcinoma of bladder; " " liver
Due to: Nephritis (acute)
Primary carcinoma of bladder:
Due to: Duration: one and a half years.
metastasis to liver: six months.
Other conditions: [illegible]
(Include pregnancy within 3 months of death)
Major findings: None
Of operations
Of autopsy: None

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. C. Jennette, M.D. M. D. or other
Address: Westminster Md Date signed: 3-21-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

No [illegible] Number

RECEIVED
APR 4 1949
BUREAU V. S.

St address in BC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03023

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 7 yrs 9 mo 1 da

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Baltimore Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 4221 Belview Ave (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Almedia Banks Gourex

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: —

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 7th - 1868

8. AGE: Years: 71 Months: 9 Days: 3 If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation:

11. Industry or business: not any

FATHER
12. Name: Andrew L. Banks
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Mary Barber
15. Birthplace: Virginia

16. Informant: Jean Gourex

Address: 4221 Belview Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 18 1940 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemetery

Location: Pikesville Md

18. Funeral director: Chas. E. Franck

Address: 802 Madison Ave. Balto Md

19. 3-11-40 (Date rec'd by registrar) 19 Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11th 1940, at 6 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1939, to Mar 11 1940, and that I last saw her alive on Mar 11th 1940.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 5 days

Due to: Tubercular Spine — 2 yrs

Due to: Arterio Sclerosis — 10 yrs

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. J. Martin M. D. or other

Address: Sykesville Md Date signed: Mar 11-40

RECEIVED
APR 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03024

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1yr., 6 mos., 19 days

Stay in this community (yrs., or mos., or days): 1yr., 6 mos., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Sykesville Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME: Euratle Ann Zenty

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Abraham M. Zenty

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 9, 1864

8. AGE: Years	Months	Days	If less than one day
75	5	11	____ hrs. ____ min.

9. Birthplace: Carroll County, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Joseph Caple

13. Birthplace: Maryland

MOTHER 14. Maiden name: Rebecca Stickling

15. Birthplace: Maryland

16. Informant: Mrs. J. A. Hardy

Address: Catonsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 23 1940 (month) (day) (year)

Cemetery or crematory: Providence

Location: Hamber Md

18. Funeral director: Jr. Francis Reese

Address: Westminster, Md.

19. 3-20-40 (Date rec'd by registrar) 19____ C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20, 1940, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1, 1938, to March 20, 1940, and that I last saw h[illegible] alive on March 20, 1940.

Immediate cause of death	DURATION
Hypostatic Pneumonia	7 days
Cerebral Hemorrhage	3 days
Due to Hypertensive Cardio Vascular disease	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Joseph H. Marshall, M.D. M. D. or other

Address: Springfield State Hospital Date signed 3-20-40

RECEIVED
APR 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

03025

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Springfield State Hospital
Stay in hospital or inst. (yrs., or mos., or days) 4 yrs. 3 mo. 12 da.
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Nannie Catherine Repp

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single.

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1884

8. AGE:

Years	Months	Days	If less than one day
55	7	20	hrs. min.

9. Birthplace Carroll County, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Thomas Repp
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Elizabeth Devilbiss
15. Birthplace Carroll Co Md

16. Informant Hospital Records
Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-6-40 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster Md.

18. Funeral director H. C. Bankard & Sons
Address Westminster Md.

19. 3-5-40 (Date rec'd by registrar) 19 Cherry Wine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1940, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 27 1940, to March 5 1940, and that I last saw h-ve alive on March 4 1940.

	DURATION
Immediate cause of death Colon Pneumonia	7 days
Due to	
Due to	
Other conditions Sacculated Melanosarcoma	1935

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Schelling M.D.
M. D. or other
Address Sykesville Md. Date signed 3-5-40

RECEIVED
APR 3 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

03026

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 mo - 26 days -

Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2620 Violet Ave -
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Harry Zimmerman

3. (b) Social Security Number: Pass. 093-09-9577

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Sarah Shapiro - Died 1918

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): September 12 - 1890

8. AGE:

Years	Months	Days	If less than one day
49	6	1	____ hrs. ____ min.

9. Birthplace: Buenos Aires - South America
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business

FATHER
12. Name: Morris Zimmerman
13. Birthplace: Russia

MOTHER
14. Maiden name: Anna Fedder
15. Birthplace: Russia

16. Informant: Hospital Records

Address: Sykesville, Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: 3-14-40 (month) (day) (year)

Cemetery or crematory: Mt Carmel Road Cem.

Location

18. Funeral director: Jack Lewis Inc

Address: Balto & Caroline Sts

19. 3-13-40 19 C. Harry Weir
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1940, at 1:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 16 1939, to March 13 1940, and that I last saw him alive on March 13 1940.

Immediate cause of death	DURATION
Bronchopneumonia	March 10-1940
Due to	
Due to	
Other conditions: Manic Depressive Psychosis Depressed Phase	Nov. 16 1939 -

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy: as above

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: M. Virginia Beyer M.D. -
M. D. or other

Address: Sykesville, Md Date signed: March 13-40

RECEIVED
APR 3 1940
BUREAU V. S.